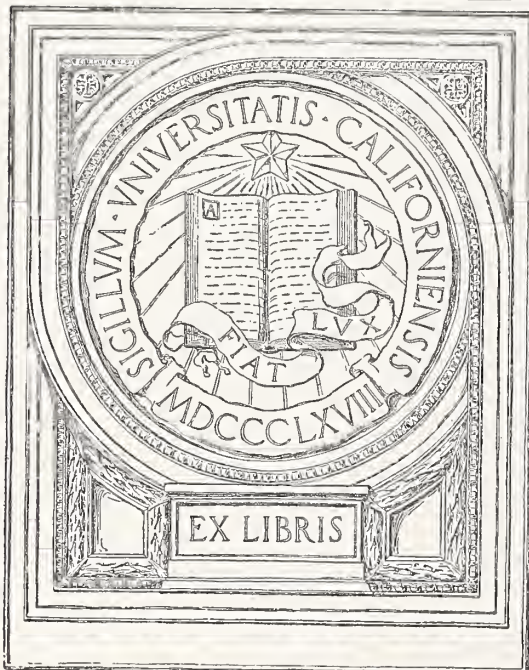


UNIVERSITY OF CALIFORNIA
SAN FRANCISCO MEDICAL CENTER
LIBRARY





Digitized by the Internet Archive
in 2016

<https://archive.org/details/journalofindiana602unse>

Indiana state med Assoc.
Jl.

U.C. MEDICAL CENTER LIBRARY

JUL 27 1967

San Francisco 94122

J-0-P
Univ. Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122

12-67

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

Indianapolis, Indiana

July, 1967

Vol. 60 • No. 7

some allergens are green

whatever their color,
shape, or size...

Benadryl[®]

(diphenhydramine hydrochloride)

PARKE-DAVIS

for control of
allergic symptoms



Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. **INDICATIONS:** Antihistaminic, antispasmodic, antitussive, and antiemetic therapy.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine

has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. **ADVERSE REACTIONS:** Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals[®] of 50 mg. and Capsules of 25 mg.

00867

The pink capsule with the white band is a trademark of Parke, Davis & Company.

PARKE-DAVIS

BSP® DISPOSABLE UNIT

W&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®

OMSULPHALEIN®
IN A COMPLETE,
STERILE,
DISPOSABLE,
& ECONOMICAL
PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor—the most costly commodities.

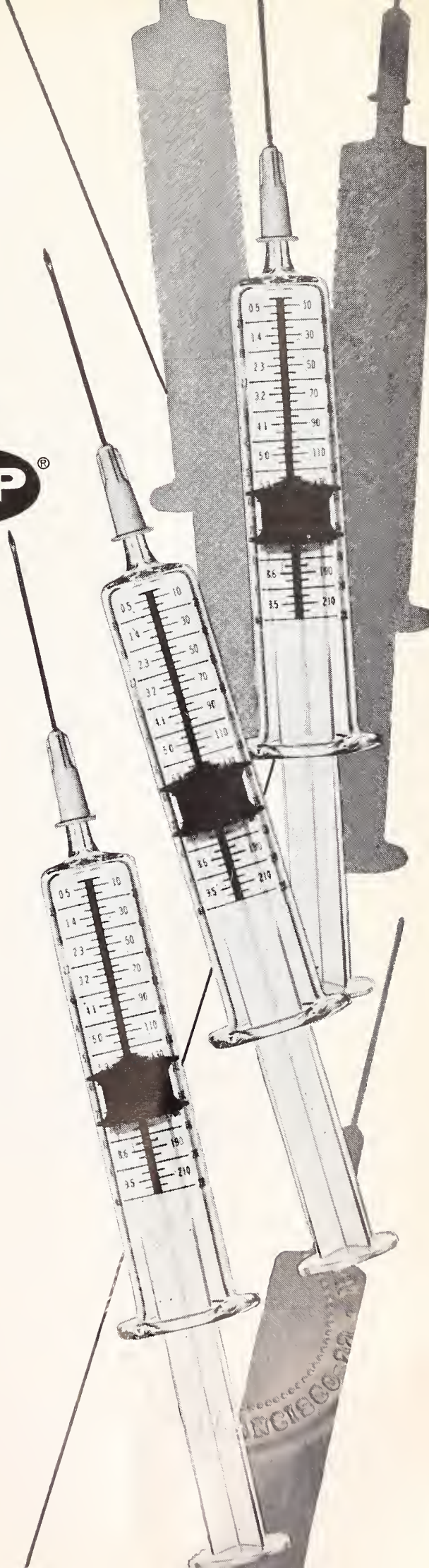
HYNSON, WESTCOTT & DUNNING, INC.



(BSP03)

BALTIMORE, MARYLAND 21201

221955



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report , John R. Poncher, M.D., Valparaiso; William F. Rowley, M.D., Howard S. Traisman, M.D., Chicago, Ill.	907
Cervicitis and Benefits from Cauterization , Frank W. Peyton, M.D., Lafayette	910
Spectrophotometric Examination of Amniotic Fluid as a Means of Predicting Severity of Intrauterine Erythroblastosis , Paul F. Muller, M.D., Indianapolis	914
The Control of Biosynthetic Systems , David M. Gibson, M.D., Indianapolis	918
The Case of the Mystifying Myelopathy , Arnold Lieberman, M.D., New York, N. Y.	920
Fractures and Orthopedic Problems: Posterior Dislocations of the Shoulder , George F. Rapp, M.D., Indianapolis	923
Electrocardiogram of the Month: Pulmonary Emphysema vs. Myocardial Infarction , Charles Fisch, M.D., Indianapolis	927
X-Ray Conference: The Arteriographic Diagnosis of Periarthritis Nodosa , Erich K. Lang, M.D., Indianapolis	928
The Cancer You View , Edwin E. Pontius, M.D., Indianapolis	930

EDITORIALS

Hospital Supply Sales up, Up, UP	931
Intrauterine Transfusion , David A. Bickel, M.D., South Bend	931
The Old Crouch Fights Back	932
Medicare—Diagnosis and Treatment (Guest)	933
The World Medical Association, Inc. (Guest)	934
Editorial Notes	934

SPECIAL FEATURES

Meet The Journal Staff	944
"North to Alaska"	949
Medical Students Urged to Stay in Indiana	950

REGULAR FEATURES

Month in Washington	896
From The Journal Fifty Years Ago	898
Fourth Estate	902
President's Page	946
The Woman's Auxiliary Reports to ISMA	948
Cleaned from the British Medical Journal , Jack W. Hickman, M.D., Indianapolis ...	952
Medicine At Law	956
Blue Cross-Blue Shield News (One of a Series)	960
Abstracts, Book Reviews	962
News Notes	971
Medical Panorama: More Light on Monilial Vaginitis , A. W. Cavins, M.D., Terre Haute	976
Wanted: Locations, Physicians	976
Future Meetings, Seminars, Courses	978
Annual Meeting Dates of Professional Medical and Allied Organizations	979
Board of Health Report	982
County, District News	983
Deaths	984

BUSINESS

Executive Committee: April 8, 1967	986
The Council: April 9, 1967	987

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.


Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Poplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice of Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 905.



For people who eat more than one meal a day

A PLEGINE (Phendimetrazine bitartrate) tablet taken an hour before each meal affords peak activity at mealtime, when it is needed most. Reminds patients to eat according to your prescribed diet plan.

t.i.d./Plegine[®]
BRAND OF
Phendimetrazine bitartrate
provides peak appetite suppression when it's needed most

Indications: Recommended in the management of excessive appetite leading to obesity.

Cautions and Contraindications: No adverse effects on blood pressure, heart rate, and respiration have been reported. However, as is true for all medications of this type, PLEGINE (Phendimetrazine bitartrate) is not recommended for patients with coronary disease, severe hypertension, or thyrotoxicosis, and should be used with caution in highly nervous or agitated individuals.

Side Effects: There have been occasional reports of insomnia and nervousness. Rare instances of mouth dryness, nausea, blurring of vision, dizziness, constipation, and stomach pain have been noted.



AYERST LABORATORIES New York, N.Y. 10017 • Montreal, Canada

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 9-12, 1967—INDIANAPOLIS

OFFICERS FOR 1967-68

President—Eugene S. Rifner, M.D., Van Buren 46991.

President-Elect—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

Treasurer—Ottis N. Olvey, M.D., 3231 N. Meridian, #11, Indianapolis 46208.

Assistant Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scottsburg 47170.

Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian, Indianapolis 46208.

Legal Counselor—Mr. Robert Hollowell, 1440 Consolidated Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—P. J. V. Corcaran, Evansville.....	Oct. 1968
2—Jae Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1967
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntash, Riley	Oct. 1969
6—William R. Tindall, Shelbyville	Oct. 1967
7—Albert M. Donata, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1967
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Lagansport	Oct. 1969
12—Milton F. Papp, Fort Wayne	Oct. 1967
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	1967
2—.....
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1967
5—A. W. Cavins, Terre Haute	1967
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1967
9—Clarence G. Kern, Lebanon	Fall, 1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokama	1969
12—William Clark, Fort Wayne	Spring, 1968
13—George B. Gattman, Elkhart	1967

SECTION OFFICERS 1967-68

Section on Surgery:

Chairman—Joseph C. Finneran, Indianapolis
Vice-chairman—Donald M. Schlegel, Indianapolis
Secretary—Henry Larzelere, Marion

Section on Internal Medicine:

Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—Lewis E. Marrison, Indianapolis
Vice-chairman—M. Richard Harding, Indianapolis
Secretary—Gerge A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—Eugene Schmidt, Fort Wayne
Vice-chairman—William M. Matthews, Indianapolis
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Ross Egger, Middletown
Vice-chairman—Jay S. Reese, Martinsville
Secretary—Robert Mouser, Indianapolis

Section on Obstetrics and Gynecology:

Chairman—Joseph F. Thompson, Indianapolis
Vice-chairman—Robert M. Reid, Columbus
Secretary—Tom W. Wachob, Jr., Kokoma

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Lavis C. Bixler, Blamington
Vice-chairman—Richard A. Silver, Indianapolis
Secretary—William A. Anshutz, Indianapolis

Section on Nervous and Mental Diseases:

Chairman—Donald F. Maore, Indianapolis
Vice-chairman—Hans Meyer, Westville
Secretary—Gene E. Lynn, Indianapolis

Section on Pathology:

Chairman—Joseph L. Haymond, Indianapolis
Vice-chairman—Robert J. Frost, Michigan City
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Randall E. Miller, Lafayette
Vice-chairman—Wendell E. Brawn, Indianapolis
Secretary—Marris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1967:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownsstown	Dwight W. Schuster Indianapolis

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	James H. Gasman Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumann, Lafayette

A large, dark, grainy microscopic image showing numerous spermatozoa. The sperm heads are visible as bright, oval shapes, some with long, thin tails extending outwards. In the upper left corner, there is a smaller, rectangular inset image showing a different view of the same or similar material, with more densely packed, bright, circular structures.

New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1— a combination of both low-dosage progestogen and estrogen for the full treatment cycle— may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

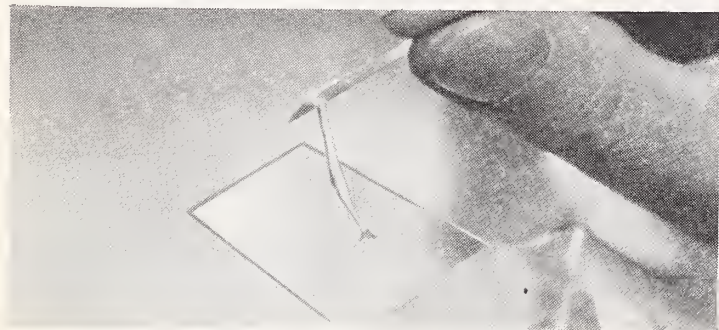
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

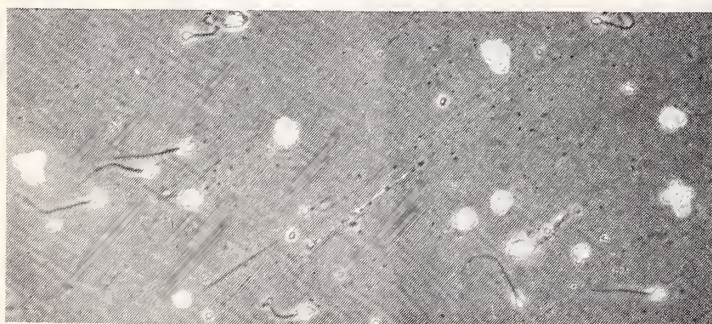
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

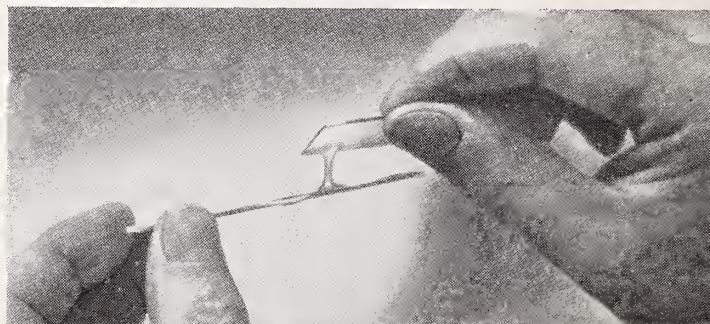


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

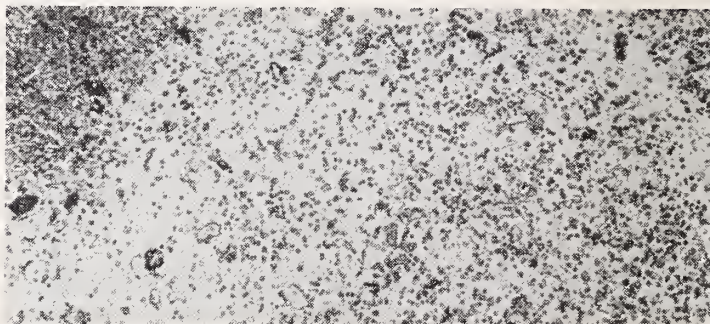


Spermatozoa appear healthy, are active and freemoving.

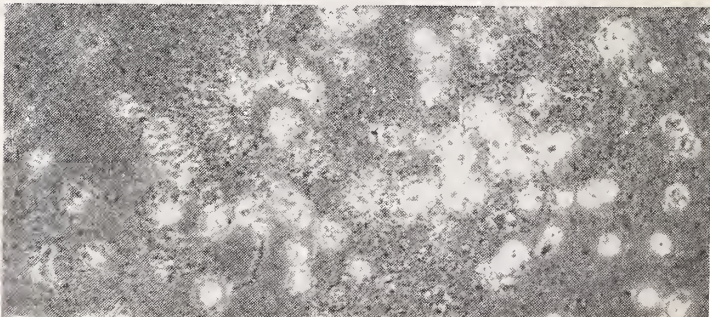
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

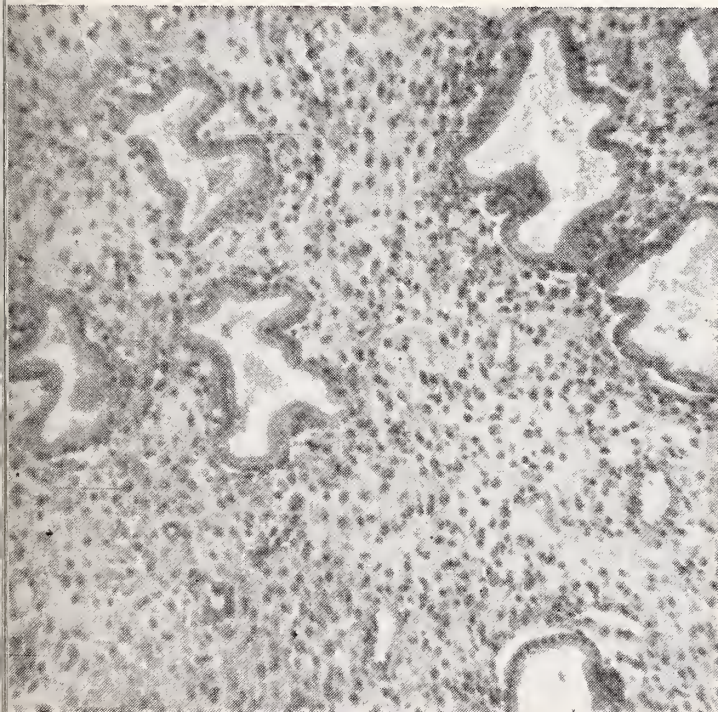


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses— another possible protective mechanism

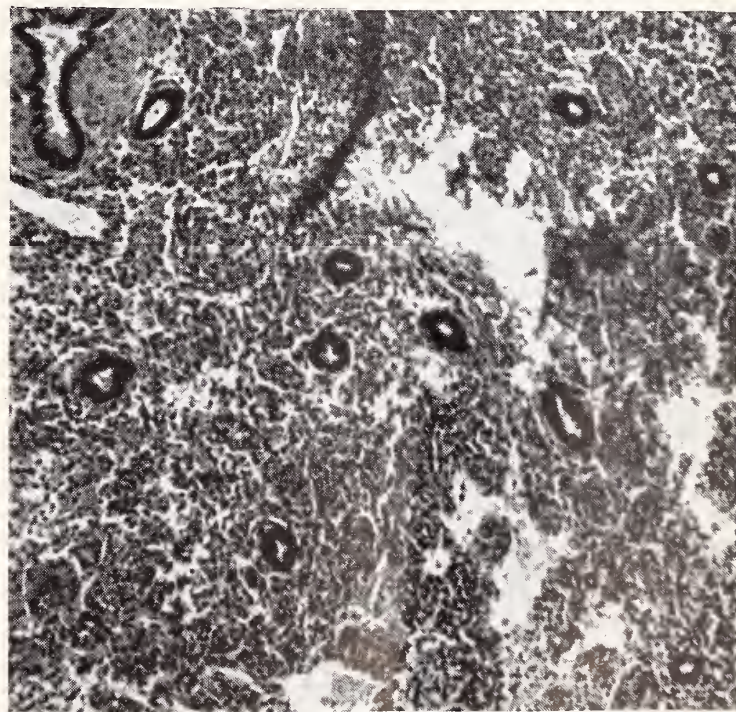
Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, the additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of
untreated patient



Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced
by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new
Norinyl-1[®]
(norethindrone 1mg, ♂ mestranol 0.05mg.) **tablets**

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

^{new} Norinyl-1[®]

(norethindrone 1mg. \bar{c} mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are

indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be

altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metapyrone test, pregnandiol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. For complete clinical data, see package insert.

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20 day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; Eugene S. Rifner, Van Buren, President; G. O. Larson, LaPorte, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Ottis N. Olvey, Indianapolis, Treasurer; Lester H. Hoyt, Indianapolis, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Glock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis, secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Gootee, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Glock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholty, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hovda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Oklahoma Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Markleville; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseney, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordsville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammond; Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry C. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veederburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donalo M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordsville.

Voluntary Health Agencies

Norman R. Bocher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Hobgood, Evansville	
2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Harold W. Richmond, Columbus	David L. Adler, Columbus	
5.	Thomas J. Conway, Terre Haute	Arnold W. Kunkler, Terre Haute	
6.	J. J. Farrell, Jr., Greenfield	Perry Seal, Brookville	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	
10.	R. James Bills, Gary	John J. Reed, Hobart	
11.	Joseph Bean, Logansport	Fred Poehler, La Fontaine	Logansport, Sept. 13, 1967
12.	Max M. Gitlin, Bluffton	Berniece Williams, Fort Wayne	
13.	Gordon Cook, South Bend	John Hildebrand, South Bend	South Bend, Sept. 27, 1967



Optimil[®]

THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.¹⁻⁵

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.⁶ (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.⁷⁻⁹

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: *Pediatrics* 33:94, 1964. 2. Hepner, R., et al.: *Pediatrics* (to be published). 3. Hansen, A. E., et al.: *Pediatrics* 31:171, 1963. 4. Holman, R. T.: *Fed. Proceed.* 23:1062, 1964. 5. Holman, R. T., et al.: *Amer. J. Clin. Nut.* 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: *J. Nut.* 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: *ibid.* 9. Nichols, M.: *ibid.*



Optimil, the first optimum-nutrition infant formula

from a world leader in nutritional research... **Carnation[®]**

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe
Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Griffith Marr, Columbus
A. L. Coddens, Earl Park
Robert H. Wiseheart, Lebanon
Don J. Wagoner, Delphi
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
J. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazey, Washington
Alfred K. Rhodes, Lawrenceburg
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
William E. Garner, Jr., New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waitt, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
James S. McElroy, New Castle
Donald Fields, Kokomo
Reeve Peare, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisett, Madison
George Brown, Greenwood

Robert J. Nichols, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford
Robert D. Williams, Markleville
William B. Lybrook, Indianapolis

Marshall Stine, Bremen
Parker W. Snyder, Peru
Claude N. Thompson, Waynetown
Ellery T. Drake, Martinsville
Leon E. Kresler, Kentland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington
John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Clackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Phillip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
John R. Dragoo, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David C. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave.,
Fort Wayne

Mr. Larry L. Pickering, Exec. Secy.,
212 Med. Ctr. Bldg., Fort Wayne
Donald L. Sandlin, 2530 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
James R. McAfee, 1005 N. East, Lebanon
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street,
Logansport

Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St.,
Frankfort

C. Philip Fox, 305 Peoples Bank, Washington
J. Kenneth Jackson, 223 Mechanic St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntingburg
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman

Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert C. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren

William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St.,
Franklin

Charles L. Miller, 301 American Bank Bldg.,
Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave.,
Gary

Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave.,
LaPorte

Glen D. Ley, 2900 W. 16th St., Bedford
William M. Stimson, 333 Jackson St., Anderson
Charles W. Cure, 1815 N. Capitol Ave.,
Indianapolis

Mr. Arthur C. Loftin, Exec. Secy., 2902 N.
Meridian, Indianapolis

Cecil R. Burket, 424 W. South St., Bremen
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 10½ N. Main St., Martinsville
Arthur Schoonveld, Brook

Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Charles Emery, 400 E. 3rd St., Bloomington
Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital,
Valparaiso

Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe,
South Bend

Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E.
3rd, Evansville

Robert L. Meissel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

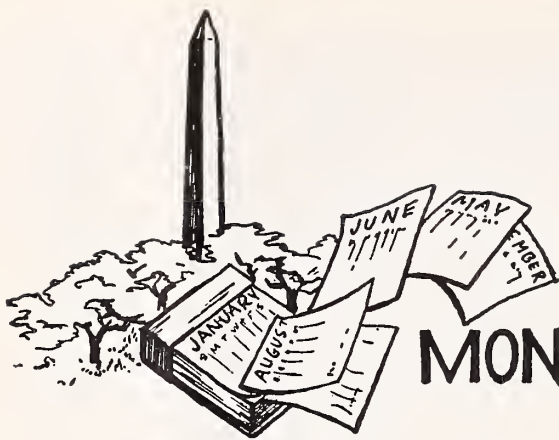
Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* in-

volving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to stay strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The Department of Health, Education and Welfare is making a broad study of prescription drugs which will be the basis of a recommendation on whether their costs should be covered by medicare when they are used outside a hospital.

HEW SECRETARY John W. Gardner appointed a task force of HEW officials to evaluate the study and make the recommendation.

"PRESCRIPTION drugs are an essential element of modern medical care," Gardner said. "In the last 25 years we have witnessed greater advances in the use of drugs than in the whole previous history of medicine. Today drugs and biologicals make possible the prevention and successful treatment of illnesses that were serious and frequently fatal.

"YET for many older Americans the cost of needed drugs prescribed by a physician is a heavy burden, representing 15 to 20% of their medical care costs. Many older Americans find themselves with limited financial resources at the very time that age brings an increasing incidence of chronic disease and greater needs for medical care, including prescription drugs."

PRESIDENT JOHNSON directed last January that Gardner "undertake immediately a comprehensive study of the problems of including the cost of prescription drugs under medicare." Studies on some aspects of the question were started then and are near completion. Other specific studies are in various stages of progress.

BUT Congress may decide the issue before the full study is completed. The Senate Finance Committee will hold hearings this summer on such a medicare extension.

DR. PHILIP R. LEE, Assistant HEW Secretary and chairman of the task force, said that even if the study is incomplete, HEW will take a stand anyway when the Senate Finance Committee takes up the legislation.

ONE BILL would finance medicare coverage of drugs by increasing from \$3 to \$4 the cost of monthly premiums for the voluntary doctor bills insurance program (Plan B) for persons 65 and over. Sponsored by Sen. Joseph M. Montoya (D., N.M.) the bill would provide that generic drugs rather than trade name products be used whenever possible.

ANOTHER BILL is sponsored by Chairman Russell B. Long, (D., La.), the Senate's leading critic of the drug industry. It would spur generic purchasing for all federally-connected welfare programs.

"THE TASK FORCE will examine a number of factors which are closely involved with the use of prescription drugs and with present and proposed methods of purchasing them," Lee said. "Many of these factors concern not only drug costs—and who pays them—but also the quality of medicare care."

AMONG the major areas listed for task force study:

1. Present patterns of drug prescription by physicians.
2. Present patterns of prescription drug use and expense by patients.
3. Present resources used to meet drug costs (including personal resources, aid from relatives, insurance, government assistance).
4. Present drug cost coverage programs (including federal, state, commercial insurance, union, and foreign programs).
5. Distribution systems (including independent pharmacies, central pharmacies, mail-order distribution, physician dispensing, and hospital dispensing).
6. Reimbursement factors (including determination of costs; co-insurance; deductibles; and limitations on dollar costs, drug quantities, and drug types).
7. Accounting methods (including nomenclature, coding, data processing).
8. Pharmacological aspects (including generic equivalents vs. clinical equivalents).
9. Clinical aspects (including formulatory systems).
10. Legal and fiscal aspects.
11. Impact of proposed methods of purchasing prescription drugs on costs and quality of patient care, on medical profession, on pharmacy profession, on drug industry, on government.

"MEASLES SHOULD BE ERADICATED THIS YEAR"

SURGEON GENERAL William H. Stewart says that measles (Rubella) should be eradicated this year but other cripplers and killers like venereal disease and cancer still baffle researchers.

"THIS YEAR, 1967, may well go down in history as the year of measles eradication in the United States", Stewart told a House Appropriations Subcommittee, in testimony recently published.

STEWART said the measles vaccine, licensed four years ago, is "bringing the disease to the vanishing point." The Public Health Service researchers now are working with an "experimental vaccine" trying to conquer German measles, he said.

OTHER health problems, such as cancer, heart disease and gonorrhea, continue, however, to pose numerous research problems, Stewart reported.

STEWART told the Appropriations Subcommittee that the "fastest rising causes of death and disability" in this nation are emphysema and other chronic respiratory diseases. He said deaths from emphysema and chronic bronchitis have increased about nine times in the last 20 years, causing more than 60,000 deaths a year.

THE federal health official, who estimated that some 300,000 people die each year indirectly from smoking, also reported that a new less dangerous cigarette maybe developed.

"THERE is reason to believe that the development of a less hazardous cigarette is potentially within reach," he said. But he put no timetable on development of this type of cigarette.

AMA SUPPORTS AIR POLLUTION PROGRAM (ALMOST)

THE American Medical Association supports all except one provision of legislation (S. 780) that would expand the federal government's

Continued

role in the federal-state program to curb air pollution.

IN A LETTER to the Senate Subcommittee on Air and Water Pollution, Dr. F. J. L. Blasingame, executive vice-president of the AMA, pointed out that the AMA has been directing the attention of physicians and other health workers to the problems of air pollution through a series of meetings and its publications. He also noted that the AMA has supported such legislation in past years.

"IN spite of past legislation and on-going federal, state and local programs which are carried on in cooperation with private industry, the American Medical Association recognizes that air pollution continues as a major environmental problem," Dr. Blasingame said. "Increased program emphasis on research and development in technics of air pollution control and abatement is worthy of the support of the medical profession.

"THE BILL before you contains one provision which we cannot support. Section 107 of S.780 would require the Secretary of HEW to establish emission standards for certain industries. On the basis of present information and understanding of the relationship between emissions and the effect it has on surrounding air, such a requirement is unrealistic and would not accomplish its intended purpose."

From *The Journal* 50 Years Ago

. . . The failure of the mass of the profession to realize the importance of the "acute abdomen" and the fact that if we expect a patient to have a reasonable chance of recovery he must be operated on within the first 48 hours. If the diagnosis is not made until the third day, the mortality mounts to 65 or 70% and on the fourth day or later chances for recovery are very remote. It is true that the early recognition of obstruction is often very difficult, but as the conditions with which it is liable to be confused are nearly all surgical the demand for early consultation between the internist and the surgeon is most urgent.

The responsibility for this mortality rests also, but to a less extent, on the surgeon, because the principles involved in the management of these cases are not clearly enough understood. Perhaps our greatest error is the failure to recognize the importance of dealing with the toxic intestinal contents. We operate, relieve the obstruction, and are surprised to see the patient die within 24 or 48 hours from toxemia. Ninety percent of intestinal obstructions are in the small intestines, and if the obstruction has existed more than a few hours the obstructed loop should be brought out of the abdomen, carefully surrounded by hot packs, opened and emptied by inserting a straight glass tube after the method of Myonihan. Mixter, who has had an extensive experience in these cases, believes that multiple punctures with a trocar and closure with a purse-string suture is the best way to relieve the distended bowels. In a few desperate cases, after relieving the obstruction, I have sewed a small catheter into the bowel after the manner of Witzel's gastrostomy and then lightly fastened the intestine to the abdominal wall by two or three fine catgut sutures, and have been surprised to see a favorable outcome.—J. C. Fleming, M.D., "Factors which Contribute to Safety and Success in Surgical Procedures," *JISMA*, July, 1917.



For your protection . . .

injections in this office are given with TUBEX*, using
a new, sterile disposable unit with a new, supersharp,
stainless steel, siliconized sterile needle

. . . designed for one use only.

*TUBEX® Closed Injection System, Wyeth
PRINTED IN U.S.A. — CODE 7409

Your name
on the dotted line
can mean so much
to your patients

And to you

.....The TUBEX[®] Closed-Injection System means

Efficiency and convenience

TUBEX injectables are ready for immediate use. No measuring of doses; no filling of syringes. Saves professional time. Easy to store in the office, easy to carry on house calls.

Precision and protection from cross contamination

TUBEX injectables are premeasured, accurately and clearly identified as to name, dose, control number and expiration date (if any). Used once, then discarded, TUBEX prefilled sterile cartridge-needle units cannot cause cross contamination.

Coverage of virtually all injection needs

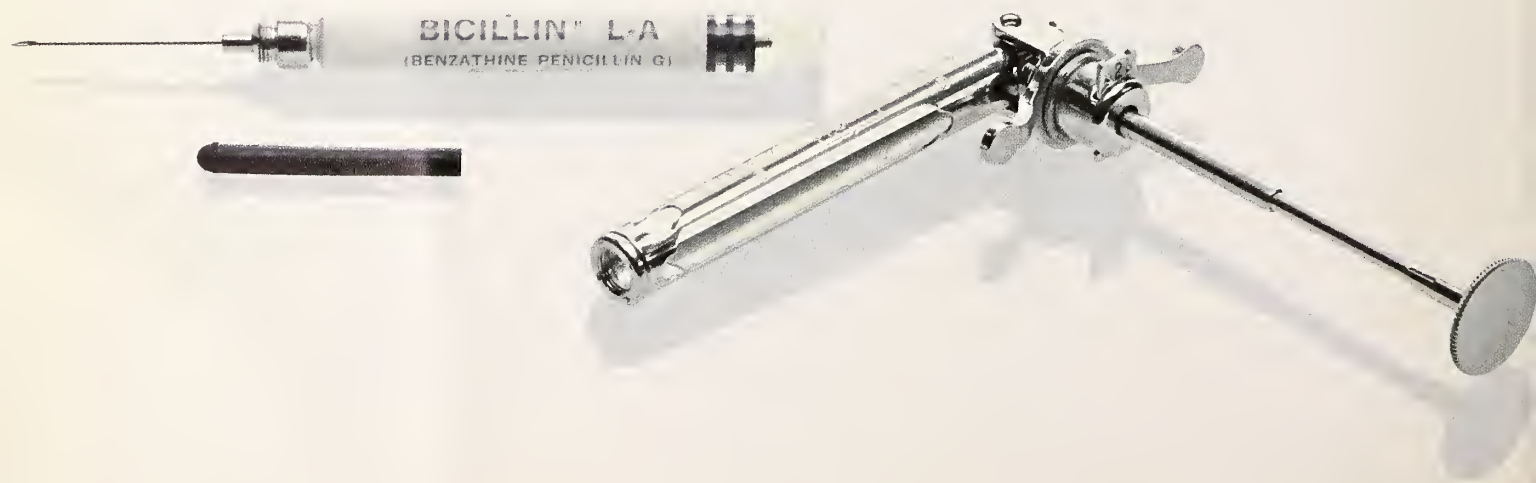
The wide range of drugs available in TUBEX sterile cartridge-needle units can meet over 70% of common private practice injectable needs. For drugs not yet in TUBEX form, empty sterile cartridge-needle units can usually be employed—and retain most advantages of the system.

TUBEX[®] Closed Injection System



If you are already using TUBEX in your office and don't have a waiting-room placard, Wyeth will be happy to send you one. A postcard will do.

Wyeth Laboratories
Professional Service
Box 8299
Philadelphia, Pa. 19101



MAKE YOUR ROOM RESERVATIONS NOW!

for the 118th

Annual Convention of the

Indiana State Medical Association

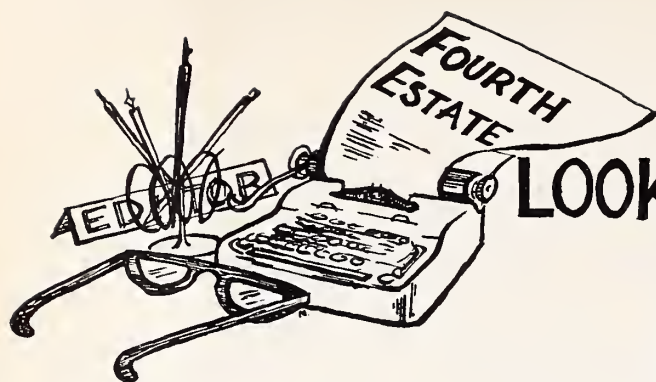
House of Delegates opening session

2:00 p.m., Monday, October 9, 1967

	Single	Double and Twins	Suites
<hr/>			
Antlers Hotel 750 N. Meridian	6.50 - 10.00	11.00 - 13.00	
Claypool Hotel 14 N. Illinois	8.50 - 12.00	14.00 - 18.00	35.00 - 50.00
Sheraton-Lincoln 117 W. Washington	8.50 - 11.85	14.85 - 15.85	32.00 - 52.00
Marott Hotel 2625 N. Meridian	9.00 - 15.00	13.00 - 18.00	30.00 - 50.00
Stouffer Inn 2820 N. Meridian	12.00 - 20.00	16.00 - 26.00	26.00 - 40.00
Holiday Inn 500 W. Washington	11.00 - 12.00	15.00 - 16.00	20.00, 25.00
Holiday Inn 1920 N. Meridian	11.00	12.00	20.00
Howard Johnson's 501 W. Washington	11.00 - 18.00	12.50 - 16.00	20.00, 25.00

* Rates subject to change

YOU ARE ADVISED TO REQUEST RESERVATIONS
EARLY TO ASSURE YOU OF YOUR CHOICE OF
HOTEL AND ACCOMODATIONS



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

PERSONALLY SPEAKING

Suppose Social Security Was Voluntary

By Jameson G. Campaigne
(Editor of The Star)

(Second of Three Columns)

Suppose Social Security were made voluntary. Suppose every American now paying Social Security taxes for retirement and other benefits could choose to invest this money in private savings or insurance programs. What would happen?

The first thing that would happen would be that the vast majority of the people would choose private investment. The reason is that they would receive twice as much or more from private investment programs than they would from Social Security.

The second thing that would happen would be that the vast funds now going into the government for Social Security would be pouring into private enterprise which would vastly stimulate American economic growth. With even faster economic growth the government would be collecting higher and higher revenues in income taxes and other taxes. Any present Social Security obligations of the government could easily be paid for from general revenues. The Social Security bureaucracy could be cut way down, saving more money.

But who would then take care of the improvident, the poor, the person who cannot or does not save for the future? There are several answers.

They could be taken care of by the present welfare system supported by state and federal funds. They could be taken care of by a shrunken Social Security system financed from general revenues. They could be taken care of by a "negative income tax" suggested by economist Milton Friedman which, incidentally would cost only half of what our present welfare and social security systems cost.

If a negative income tax were instituted, the Internal Revenue Service would pay out, instead of taking in, enough money to raise the incomes of the poor or retired or ill to a level of, say \$3,000 a year, the present highest Social Security payment. Friedman estimates that we could pay *one third* of our population \$2,000 each and it would cost no more than the present programs. Incidentally only 12% of American families earn less than \$2,000 a year right now. In my opinion, Friedman's plan could only work if the people receiving negative income taxes—subsidies—were denied the right to vote in national elections. Thus they could not vote themselves more and more of somebody else's money.

The point is, however, that it is quite possible to make Social Security voluntary. It is very profitable for the vast majority of Americans to make it voluntary for they would be getting twice the benefits they are now promised. The people already receiving Social Security would not suffer at all. They would continue to receive their incomes as they are, or even at a higher level. Nor would

the taxpayers suffer. It would cost them less in taxes to finance these benefits.

About 10 years ago I wrote a series of editorials for *The Star* predicting that one day the cost of Social Security to the workers was going to be more than they could ever receive in benefits. That day is here. In time the voters will discover this. The vast army of young men and women now going into business and industry will find they are being shortchanged by their government. They are being taxed to pay for the benefits of those now retired. Their children will be taxed even higher to pay theirs. And the irony of it all is that if the government let private investment do the job everybody would be twice as well off.

I venture to predict now that in 10 years time the Social Security system, as we know it, will be replaced, largely by private pension programs. For the good of all Americans, it should. (The last column will appear next month.)—*The Indianapolis Star*, March 20, 1967.

A Fine Doctor, a Fine Citizen

Dr. Elton R. Clarke will be remembered for many things—not only for the fact that he was a practicing physician (and a good one) in Kokomo for 37 years, but for his interest and active participation in community as well as medical affairs and his buoyant personality.

He had been a general practitioner here since 1926, enjoying the status of one of the city's most popular

doctors during his active career and continuing his professional work on a part-time basis after his health had been impaired in 1959.

He found time to take a role of leadership in medical circles in addition to caring for his large practice. His most distinguished office was that of president of the Indiana State Medical Association, the only Howard County man ever to hold that honor.

He took part in county and national medical association activities as well as the state organization. He was also coroner of Howard County for two terms and served one term as county health commissioner.

In his busy life he served the causes of his church and the American Legion. He was a trustee at one time of the Main Street Christian Church and was commander of Post 6 of the Legion, the post acknowledging his services by awarding him one of its few honorary life memberships in 1956.

A gentleman of high principle, he was a delightful companion. His infectious laugh and invariable good humor were characteristics which all who knew him enjoyed and will remember.

Dr. Clarke was held in great respect. He had done much for medicine in Kokomo and Howard County. Physicians throughout the state knew and liked him. He was a conscientious citizen, a man who was always willing to give of his time, energy and resources for community betterment.—*Kokomo Tribune*, May 17, 1967.

Welfare State Syndrome

Busy, bustling, booming Holland, with its cradle-to-the-grave social benefits, it appears, isn't the welfare state "paradise" it is cracked up to be.

Take the case of one Willy Puls, a talented young Dutchman who speaks four languages and is now a guide on a tourist boat that plys Amsterdam's picturesque canals.

Willy is going to Uganda in Africa. "There isn't much left to excite a young man in Holland today," he told a Copley News Service correspondent recently. "A lot of my friends don't even bother to look around. They just take a job, settle into the routine and let the years roll by."

The young Dutchmen are finding that something has gone out of their lives.

Willy calls it "excitement, opportunity, the chance to prove myself."

"I call it ambition," a leading Dutch merchant was quoted by the same interviewer.

Holland, with 12 million people crowded into an area the size of Pennsylvania, has one of the most government-regulated democracies in the world. The price of rents, food, utilities, household appliances, even theater tickets, is set by the government. It was all part of the country's post-war experiment in Socialism.

Wages and profits also are controlled, but not too successfully. Prices now are mounting steadily and are generally on a par with those in the United States. The wage barrier he'd until 1964, then went up 15%. In 1965 another 11% was added. In 1966 wages went up eight percent. New industry has created urban problems.

Socialists lost heavily in the last Dutch elections. A growing number of young beatniks, called "provos," short for provocateur, roam the land. They are unkempt, unwashed and contrast dismally to the picture of the well-groomed, modestly-dressed Dutchman.

Holland's tradition of hard work, frugality, solemnity and its passion for order seems drawn. As wages and prices push upward, Dutch productivity is going down. A businessman complains that it now takes four to do three men's work.

"Why should they exert themselves" he said. "The government promises full employment. I couldn't

fire them without a permit. And if I did, it couldn't buy ambition."

The workers complain, too. They must get a permit to move. A man who owns a home may find that the government thinks he has room for tenants—so he gets tenants whether he wants them or not.

A necessary move, say the planners.

An undemocratic situation, say an increasing number of Dutchmen.

All in all, the country's problems are identical to those which eventually befall any socialistic state. Give a man cradle-to-death security, regulate his working and personal life and you take away his initiative and his ambition. Without these there is nothing to work for. Socialistic thinkers in the United States and the rest of the world should take heed.—*The Indianapolis Star*, May 22, 1967.

Congratulations Doctor—

Congratulations and a vote of gratitude are due Dr. C. Richard Bowers for his work with the Vietnamese.

Early last week the local surgeon received the Liberty Bell Award from the Indiana State Bar Association. Previously he had received a similar award from the Madison County Bar Association.

Dr. Bowers, on two different occasions, went to Vietnam with a group of other physicians to assist in treatment of Vietnamese. Most of their work concerned civilians and the slides and stories that the doctor brought back to Anderson are evidence that much help is needed in that area.

It is only through the sacrifices of such unselfish people as Dr. Bowers that the people of America will learn the true story of that nation.

The Anderson Herald wishes to congratulate Dr. Bowers on his award but more important express gratitude to him as an individual for his patriotism and sacrifices in his effort to help other people and in-

form Americans.—*Anderson Herald*, May 9, 1967.

War on Measles

The cause of good health will get a real shot in the arm if Lake County's campaign against measles wins the support it merits.

The strategy is simple—mass immunizations of youngsters against what usually is just an uncomfortable nuisance, but too often is deadly. That strategy worked against polio and sent that once feared scourge to the sidelines.

It can do the same thing to measles. But it won't work unless parents take their children to private physicians or clinics for the shots. Those who don't will be guilty of neglect.

We're sure that doctors will cooperate in the effort, because the Lake County Medical Society has helped to develop the local program at the suggestion of the State Board of Health and the U.S. Public Health Service. It is important that physicians charge reasonable fees, so that parents won't hesitate to schedule their children for immunization.

For parents who feel they cannot afford a doctor's fee, clinics will be set up, both in Gary and in county areas, under the Gary and county health departments. Some Indiana counties have planned the inoculation programs on a free-shot basis for everyone. That isn't necessary — what is necessary is for kids to get the shots.

Physicians and health officials emphasize that measles should not be regarded as just another simple, inevitable disease. It can be dangerous, and now that weapons for preventing it are available, only a foolish parent will fail to use them.—*Gary Post-Tribune*, April 7, 1967.

Dr. Bowers Honored

Dr. C. Richard Bowers has brought favorable recognition to Anderson

and unsought honor to himself through action taken by the Indiana Bar Association in presenting the local physician with its Liberty Bell Award.

Dr. Bowers accepted the award at Law Day ceremonies at Indianapolis, where he was paid a fitting tribute for two voluntary tours of duty in Vietnam. He was cited as a good will ambassador among the South Vietnamese people and for his contribution in "strengthening and safeguarding the blessings of liberty."

A father of four sons, Dr. Bowers is providing for subsistence and educational needs of two Vietnamese boys.

Presentation of the Liberty Bell Award to Dr. Bowers brings into the spotlight the fine work that is done by dedicated people in behalf of their fellowmen.—*Anderson Bulletin*, May 3, 1967.

One Of The Best

"The 'Best' Hospitals," an editorial based on an article in a recent issue of *The Ladies' Home Journal* which sets out to pick "America's 10 Best Hospitals," appears in a current issue of *The AMA News*.

In providing *The News* with a copy of the editorial, Dr. Willard Krabill, Goshen physician, writes that many people have been upset by the inferences in *The Journal* article, people who live in smaller communities who have excellent hospital facilities.

"Maybe some of the people of Goshen have been disturbed by the article but they needn't be," Dr. Krabill writes.

"During the past year I took post-graduate work at one of the large teaching hospitals in Chicago," he said, adding "Goshen hospital need not take a back seat to this one, nor to others."

"I am very pleased with Goshen hospital, *The Ladies' Home Journal* notwithstanding," concluded the doctor's letter.

The editorial to which Dr. Krabill referred follows:

"An article in a recent issue of *The Ladies' Home Journal* sets out to pick 'America's 10 Best Hospitals,' perhaps an innocent enough exercise, but winds up accusing the vast majority of U. S. hospitals of providing less than acceptable care.

"To arrive at its list of 'best' hospitals, *The Journal* asked 10 'of the best qualified hospital judges in all parts of the country' some questions: 'If you or your family required major hospital services—diagnosis or treatment—which 25 hospitals in the United States would you select as representative of the best? Which hospitals would you put in the top 10?'"

"Not one juror," *The Journal* article reports, "was willing to call more than 175 hospitals acceptable. This means that at best only two to three percent of our hospitals provide the kind of care these men want for themselves and their families. Out of a total of some 250 votes cast, many important cities like Kansas City, Denver and Milwaukee had not a single hospital that was nominated."

"A comparison of the 'judges' and the hospitals listed shows that many of the institutions with which the judges are connected are included in the recommended hospitals. Perhaps this should be expected, for it would be impossible for the 10 'judges' to have intimate knowledge of each of the more than 7,000 hospitals in the U. S.

"By quoting occasional episodes reported to have taken place in the community hospitals, the author condemns all community and non-teaching hospitals. He implies that the alleged occurrences could not have happened in teaching hospitals. He implies that unnecessary surgery is being done on a widespread basis in community hospitals and infers that examination of removed tissue

is not being carried out widely in the community hospitals. These, and other allegations in *The Journal* article, repudiate the excellent work done by the Joint Commission on Accreditation of Hospitals.

"Without questioning the qualifications of *The Journal's* 'judges,' it must be pointed out that they are not the only qualified hospital judges in the country and that any list of 10 other men in the field might name other hospitals as the 'best.'"

"American magazines have a long tradition of useful service as social critics. It is surprising, and disappointing, to see a magazine with the stature of *The Journal* publishing an article such as "America's 10 Best Hospitals." Instead of useful criticism it is badly misleading and does not serve the public. Instead of contributing to good medical care in the U. S., it threatens to undermine the years of good work by hospitals, physicians, and such organizations as the American Hospital Assn., the Joint Commission on Accreditation of

Hospitals, and the American Medical Association."

Having been a patient at Goshen General Hospital for several weeks in the past few months, we'd like to also commend Goshen hospital for its efficiency, friendliness and cleanliness.

The only fault we can find with our local hospital is its unusually tough attitude toward public relations.

News media get little, if any cooperation from the hospital in their efforts to keep the public informed on admittances of patients, either routine or emergency.

In fact, the names of patients admitted for treatment of injuries received in traffic accidents are often deliberately and without reason withheld from publication.

The News will continue in its efforts to keep its readers informed as to who is confined to Goshen General Hospital. All we ask is a little cooperation from the hospital's administration.

If Goshen General Hospital were a

private institution, we couldn't but go along with its present policy of "it's none of the public's business" but the hospital is quite a public institution the way we see it.

First, without the public, there wouldn't be a Goshen General Hospital because it was built with money provided by public subscription with a high percentage of our population plunking down cash and making long-term pledges.

More recent public (federal) money has been used to expand its facilities and now more government money (yours and ours) is coming to the hospital through Medicare.

In addition, Elkhart County is kicking in \$80,000 annually in taxes to Goshen General Hospital.

All these things add up to one thing. Goshen General Hospital owes us more in the public relations department than we've been getting, or will be getting in the foreseeable future, from the way things are going presently.—*The Goshen News*, April 4, 1967. ◀

About Our Cover

"Little brook! Little brook!
You have such a happy look—
Such a very merry manner, as you swerve and curve
and crook—

Reach each other's hands and run
Like laughing little children in the sun!

"Little brook, sing to me:
Sing about a bumblebee
That tumbled from a lily-bell and grumbled
mumbly,

Because he wet the film
Of his wings, and had to swim,
While the water-bugs raced round and laughed at
him!

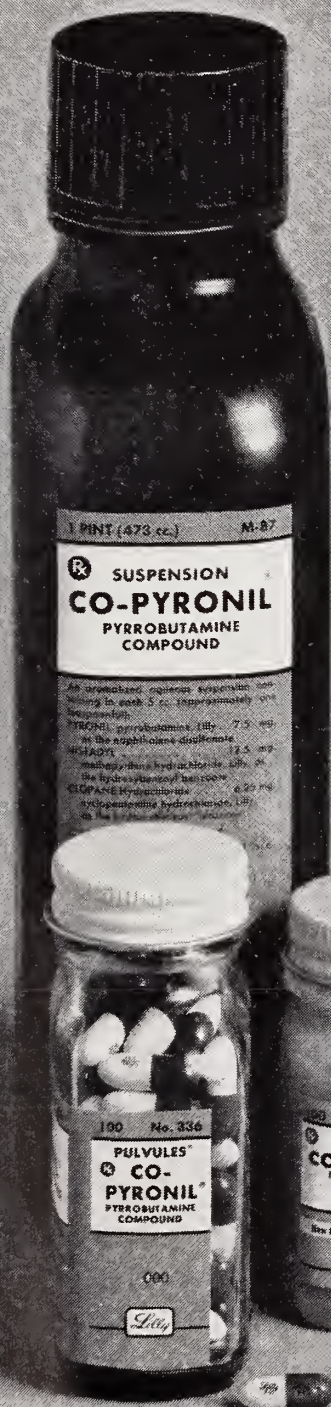
"Little brook—sing a song
Of a leaf that sailed along
Down the golden braided center of your current swift
and strong,

And a dragon-fly that lit
On the tilting rim of it,
And rode away and wasn't scared a bit.

"And sing—how oft in glee
Came a truant boy like me,
Who loved to lean and listen to your lilting melody,
Till the gurgle and refrain
Of your music in his brain
Wrought a happiness as keen to him as pain.

"Little brook—laugh and leap!
Do not let the dreamer weep:
Sing him all the songs of summer till he sink in softest
sleep;
And then sing soft and low
Through his dreams of long ago—
Sing back to him the rest he used to know!"—
James Whitcomb Riley.

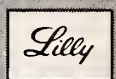
(Photo by Henry S. Wood, New Palestine).



for
quick relief
that lasts
and lasts

Co-Pyronil[®]
Pyrrobutamine Compound

Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.



790807

Reports of the coincidence of cystic fibrosis and juvenile diabetes are becoming more frequent. This and the high family history incidence of diabetes in patients with cystic fibrosis raises a question of whether the coincidence is causal rather than casual. This case and others in the literature are characterized by a low incidence of ketosis, an observation which is unexplained.

Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report*

JOHN R. PONCHER, M.D.**

WILLIAM F. ROWLEY, M.D.

HOWARD S. TRAISMAN, M.D.

IN 1958 Larsson¹ stated that diabetes mellitus rarely occurs in conjunction with cystic fibrosis of the pancreas. The purpose of this communication is to add to the literature an additional case of diabetes mellitus in conjunction with cystic fibrosis.

Case Report

A 13-year-old white male was first admitted to this hospital on October 29, 1962. A diagnosis of cystic fibrosis of the pancreas had been made six years previously at another institution. Until six months prior to this visit in 1964, he had been doing moderately well.

* From the Children's Memorial Hospital and the Department of Pediatrics, Northwestern University Medical School, Chicago, Ill.

** 1101 E. Glendale Blvd., Valparaiso, Ind. 46383.

His presenting complaints were a 25 to 30 pound weight loss in the previous two months in spite of a "good appetite", fatigue, weakness and an excessive fluid intake for one month.

He was the product of an uncomplicated pregnancy; labor and delivery had been normal. Birth weight was 5 pounds, 3 ounces. He had a bowel obstruction at birth which, the parents were informed, was caused by a "mucus plug." It resolved without surgery. The mother typifies the next six years as "large meals and large stools." He contracted pneumonia each winter until six years of age and was hospitalized from one to three times each year.

The child was described as always being small for his age. Motor and intellectual development were normal.

A male sibling died at five days of

age presumably secondary to an intestinal obstruction, although a specific diagnosis was never made. A maternal cousin and the 65-year-old paternal grandfather had diabetes.

Since the diagnosis of cystic fibrosis at age six years, the patient was relatively well with a regime consisting of a special diet, vitamins, antibiotics, monthly gamma globulin injections and pancreatin. There was a steady increase in height and weight and hospitalization was never required for respiratory infections.

His weight when seen in 1962 was 66 pounds (below the third percentile) and his height was 57 inches (seventh percentile). He was very thin, the chest appeared emphysematous and clubbing and nailbed cyanosis of the upper extremities were present.

His physical condition was much

LABORATORY DATA

			Normal Values
Serum Proteins (11/1/62)	Total	6.0 gms.%	5.7 — 6.9 gms.%
	Albumin	3.8 gms.%	3.7 — 4.7 gms.%
	Globulin	2.2 gms.%	1.3 — 2.3 gms.%
Protein Electrophoresis (11/1/62)	Gamma	0.24 gms.%	0.75 — 1.68 gms.%
	Beta	0.36 gms.%	0.59 — 1.34 gms.%
	Alpha ₁	0.42 gms.%	0.16 — 0.53 gms.%
	Alpha ₂	0.12 gms.%	0.48 — 1.16 gms.%
	Albumin	4.86 gms.%	3.45 — 4.98 gms.%
Serum Electrolytes (11/2/62)	Na	138 mEq/l	138 — 146 mEq/l
	K	4.1 mEq/l	4.0 — 5.4 mEq/l
	Cl	97 mEq/l	99 — 108 mEq/l
	CO ₂	24.5 mEq/l	20 — 25 mEq/l
Sweat Sodium (Iontophoretic) (11/1/62)		82 mEq/l	
Serum Transaminase (10/29/62)	SGOT	117 units	40 units
	SGPT	61 units	45 units
Thymol Turbidity (11/5/62)	2.0 units		0 — 4 units
BSP retention	2.5%		
Phospholipids (11/5/62)	320 mg%		160 — 310 mg%
Triglycerides (11/5/62)	110 mg%		37 — 134
Lipoproteins (11/5/62)	Beta	54 mg%	40 ± 5% mg%
	Alpha	18 mg%	15 ± 5% mg%
Serum Cholesterol (11/5/62)	155 mg%		114 — 209 mg%
Cholesterol esters (11/5/62)	70 mg%		68 — 75 mg%
Protein Bound Iodine (11/5/62)	4.3 mg%		4 — 8 mg%
Corticosteroids Urine (11/5/62)			
	17 — Keto	5.95 mg/vol.	
	17 — hydroxy	2.91 mg/vol.	
	Serum (11/3/62)	18.4 mg.%	
Creatinine (11/5/62)	0.445 gms/960cc		

TABLE 1

as described above on the present admission. His blood pressure was $\frac{100}{48}$; pulse 84; respirations 20 per minute. He was in no distress but was obviously emaciated. There was shotty cervical and inguinal adenopathy.

Examination of the chest revealed a hyperresonant percussion note bilaterally. Auscultation was normal. A chest x-ray demonstrated a right upper lobe infiltrate. An ECG was normal.

The liver was palpable 2 cm. below the costal margin in the midline on the right. The spleen was not palpable. Fecal masses were palpated in the region of the ascending and descending colon. The rectum was filled with hard irregular fecal masses. After cleansing enemas, an upright film of the abdomen showed calcific densities in the pancreas. A barium enema was normal.

Admitting urinalysis was reported as 4+ glucose. The serum glucose was 642 mgm% by the Somogyi method (Table 1).

Initially he was started on six hour management with 50 gram feedings; no insulin was given pending further lab studies. On the sixth hospital day he received insulin. Subsequently a regular program consisting of a 2,498 calorie diet with carbohydrate—308 grams; protein—112 grams; fat—94 grams; 28 units of Lente and 10 units of regular insulin daily was started. Details of our management may be found elsewhere.² On the 12th hospital day the patient was discharged with 26 units of Lente, 14 units of regular insulin and the above diet.

Of interest is that no trace of acetone was ever recorded in any of the initial urinalyses. Our first record CO₂ was 24.5 mEq/l on the fourth hospital day. The blood pH was 7.51.

We have followed this boy for two years as an outpatient. Diabetic control has only been fair because of a lack of cooperation on the part of the patient and his parents. He was last seen in our clinic on May 2, 1966, and his insulin dosage at that time

was 20 units of Lente and two units of regular insulin. He has shown a moderate weight gain over the two-year period. His 94 pounds is still below the third percentile; his height of 61 inches is just below the third percentile for his 17 years. He has managed to function at a fairly normal level, participating in school and community activities including athletics. There has been minimal unfavorable change in his chest x-ray, but no appreciable decrease in his exercise tolerance.

Comment

Prior to December, 1962, only 10 cases of diabetes mellitus complicating cystic fibrosis of the pancreas had been published in the American literature. Since then Rosan and associates³ reported a series of 10 cases (three of which had previously been reported⁴). More recently a report from the Presbyterian Hospital in Denver adds two more cases.⁵ In July, 1964, Snyder and associates⁶ reported an additional case in his series of fecal retention in children with cystic fibrosis. Rosan's 10 cases represent an experience since 1947 with some 1,300 patients with cystic fibrosis. His is the largest single series and the largest cystic population reporting coincidental existence of the two diseases to the present time. That a more than coincidental relationship between these two diseases exists is becoming more evident with each subsequent report. Koch et al.⁷ considered the relationship of these entities as well as a possible hereditary relationship. They stated that a high glucose level is "often" found in children with "severe" cystic fibrosis, and approximately one percent of these children develop diabetes mellitus requiring insulin treatment.

Rosan³ reports the incidence of diabetes mellitus in cystic fibrosis at about one in 130 as compared to one in 133 in the collective experience of others. The early interest in the relationship of these two diseases was based on the anatomical relation-

ship of the endocrine and exocrine portions of the pancreas and the extensive parenchymal destruction of the pancreas in cystic fibrosis. In the first four cases^{4,8,9} reported (from almost 400 patients with cystic fibrosis) the authors implied that this was the superimposition of one chronic disease upon another. Larsson¹ in a report based largely on experimental animal work said that despite a close morphologic relationship, the intimate anatomical relations lack any clinical or functional relationship.

Charles and Kelley¹⁰ were interested in the high frequency of a positive family history of diabetes mellitus that was found in the 25 cases of cystic fibrosis they studied. About the same time the foreign literature hinted at more than a casual relationship between cystic fibrosis and diabetes.^{7,11} Finally in December, 1962, Rosan, Shwachman and Kulczycki's convincing report.³

To our knowledge, nothing has been added to the literature in the experimental field since Larsson's work in 1958.¹

It is interesting to note the absence of apparent acidosis in the case presented here.

In Rosan's³ report they concluded that the diabetes complicating cystic fibrosis was indistinguishable from labile juvenile diabetes mellitus except for the infrequent occurrence of ketosis. They noted that this finding was worthy of further investigation.

In 1964 Rosan et al.¹² studied a group of children with cystic fibrosis and a control group (both groups included children with diabetes mellitus) in an attempt to demonstrate a metabolic defect preventing the accumulation of ketone precursors at an expected rate. Following stimulation with intravenous tolbutamide; glucose, lactate, and pyruvate were decreased in normal children, whereas only glucose and pyruvate were decreased in children with cystic fibrosis alone. The children with cystic fibrosis and diabetes mellitus

responded the same as those with diabetes alone. The authors then concluded that the antiketogenic tendency cannot be explained on the basis of abnormal accumulation of lactate or pyruvate.

Summary

A case report of cystic fibrosis and diabetes mellitus in a 13-year-old boy with a brief review of the literature is given.

BIBLIOGRAPHY

1. Larsson, Y.: The Islets of Langerhans in Pancreatic Fibrosis, *Pediatrics* 21:6, 1958.
2. Traisman, H. S.: Diabetes in Children, *J. Nat. Med. Assoc.* 54:666, 1962.
3. Rosan, R. C., Shwachman, H., Kulczycki, L. L.: Diabetes Mellitus and Cystic Fibrosis of the Pancreas, *Amer. J. Dis. Child.* 104:625, 1962.
4. Shwachman, H., Leubner, H., Catzel, P.: Mucoviscidosis, *Advances Pediatrics* 7:249, 1955.
5. Anderson, J. W., Sawyer, K. C., Sheridan, E. P.: Cystic Fibrosis of the Pancreas with Diabetes Mellitus, *Rocky Mountain Med. J.* 60:31, 1963.
6. Snyder, W. H., Gwinn, J. L., Landing, B. H., Assay, L. D.: Fecal Retention in Cystic Fibrosis, *Pediatrics* 34:72, 1964.
7. Koch, Eberhard, et al.: *Deutsche med. Wchnschr.* 86/30:1433, 1961.
8. Anderson, D. H.: Cystic Fibrosis of the Pancreas and its Relation to Celiac Disease, *Amer. J. Dis. Child.* 56:344, 1938.
9. Bodian, M.: *Fibrocystic Disease of the Pancreas: A Congenital Disorder of Mucus Production—Mucosis*, New York, Grune & Stratton, 1953.
10. Charles, R. N., Kelley, M. L.: Occurrence of Diabetes Mellitus in Families of Patients with Cystic Fibrosis of the Pancreas, *J. Chronic Dis.* 14:4, 381-85, 1961.
11. Panzram, G., Holstein, H.: Sweat Electrolyte Levels in Diabetes Mellitus as a Mucoviscidosis Symptom, *Dtsch Gesundheitsw* 17(27):1101, 1952.
12. Rosan, R. C., Kayne, H. L. L., Nieland, M. L., Shwachman, H.: Some Metabolic Responses to Intravenous Tolbutamide in Patients with Cystic Fibrosis of the Pancreas, *Metabolism* 13:480, 1964.

Actual cauterization of the cervix uteri may be performed as an office procedure for the relief of chronic cystic cervicitis, a common condition with troublesome and sometimes serious sequelae.

Cervicitis and Benefits from Cauterization

FRANK W. PEYTON, M.D.
Lafayette*

THIRTY years of private gynecologic practice have revealed chronic cervicitis to be among the most overlooked and neglected gynecological conditions existing. Cervicitis is responsible for many aggravating disturbances and disabilities and, I am convinced, even death of many women.

It is first necessary to define what cervicitis means in this presentation. It refers to the condition of any cervix which by close inspection exhibits mucus glands on the ectocervix or shows the os open with excessive glands.

Emphasis must be placed on close inspection, i.e., having good speculum exposure, a proper light and, most importantly, by removing the mucus which too frequently masks the lesion. The latter is best done by applicators dipped in Negatan (a solution of metacresol sulfonic acid with formaldehyde made by Eli Lilly & Co.) with thorough cleansing of the ecto- and endocervix. The area is then dried with dry applicators. Under such scrutiny, one finds a noteworthy incidence of cervicitis. Around 20% of nulliparas and up to 90% in the parous are realistic percentages. Cervicitis quite often is found when there are no symptoms whatsoever and casual inspections frequently overlook the condition.

The causes of cervicitis are not altogether known but definitely the stretching or trauma of dilatation such as occurs in deliveries, abortions

and operative dilatation play their part, as well as infection. Another cause is hormonal influences which provoke the growth of columnar cells from within onto the ectocervix. In the younger woman or girl, we have called it "congenital erosion or ectropion." I am convinced that the hormonal effect of the contraceptive pill, if not initiating the cervicitis, frequently aggravates the condition. Irritants such as douches and tampons can also be listed as causative factors.

Treatment

Treatment of cervicitis is the destruction of the excessive glands previously described. Simple linear office cauterization is preferred, except in the occasional marked lesion which should be coned. Spontaneous healing rarely occurs. Daily douching for months, instilling vaginal creams, or attacking superficially with chemicals such as silver nitrate or acids are practically useless. I must emphasize the importance of obtaining a recent negative cervical cytology report before any cauterization is performed.

When to cauterize is as important as how. The recommended time in the menstrual cycle is one to three days after a normal flow, so that there will be three weeks of healing prior to the next flow. If cauterization is performed later in the cycle, one can create or flare up a pelvic inflammatory disease or have excessive bleeding at the slough-time or during the first few days of the next menstrual period. Following the second

post-partum period (which is three months after delivery) when the uterus is well involuted and one is sure that the flow is a bona fide menstrual flow, is an ideal time. It is the responsibility of anyone doing obstetrics to include this as part of his care. Three or more months premaritally (of course, following a period) is good practice. Any time postmenopausally is accepted. The DON'Ts I wish to emphasize are: Never cauterize if cytology is positive; never cauterize before a period, during pregnancy, or if the patient is nursing or taking "the pill." Acute cervicitis, vaginitis or pelvic inflammatory disease are additional contraindications to cauterization.

The importance of patient-physician communication must be stressed to assure patient cooperation in returning at the correct time for treatment. This may be best handled by an informative sheet given to the patient at the time the diagnosis is made. I have found that a supplementary one-page descriptive bulletin on cervicitis given to the patient while discussing the disease with her is most helpful. She has this bulletin to refer to later. It reads as follows:

CERVICITIS

What it is, and how it is treated.

The lower end of the uterus (womb) is called the cervix, and it extends into the upper portion of the vagina. The cervical canal carries the menstrual period flow from the uterus into the vagina, permits entrance of the sperm, and dilates in labor for

*Woman's Clinic, 2400 Ferry St., Lafayette, Ind. 47904.

delivery at the end of pregnancy. The lower visible portion of the cervix is smooth and without mucus glands, while its canal is lined with mucus glands. The common general term "cervicitis" is the condition where the glands have spread out from the canal to an excessive degree and have become inflamed. Cervicitis is very common and many women suffer in silence. This is occasionally seen in early puberty, frequently following the stretching associated with delivery, and unfortunately when exposed to infection or irritants such as douches and internal tampons. These mucus glands harbor bacteria, making the cervicitis more pronounced, and many symptoms result; also, cervicitis is a potential source of development of cancer.

Frequently following a pelvic examination, I make one or more of the following statements:

"The annoying discharge is coming from the cervix.

"The irritation of the outer genitals or soreness of the vagina is aggravated by the unhealthy condition of the cervix.

"The chances for conception will be better if the cervix were healthier.

"Lower abdominal pain will leave and is less likely to recur when the infection in the cervix is gone.

"Menstrual disturbances are less likely to happen if the cervix is as it should be."

You realize, therefore, that I consider a healthy cervix most important and that it should be kept healthy and show no signs of cervicitis.

Linear cautery is the only treatment. It converts the cervix described above back to a normal smooth clean-appearing organ by burning away or destroying the diseased area on the cervix with an instrument. Streaks are made on the cervix causing slight menstrual-type cramping. An anesthetic is not required, since there is usually no sharp pain and it takes but a few minutes to do. This diseased area then heals in a most gratifying fashion correcting the conditions I

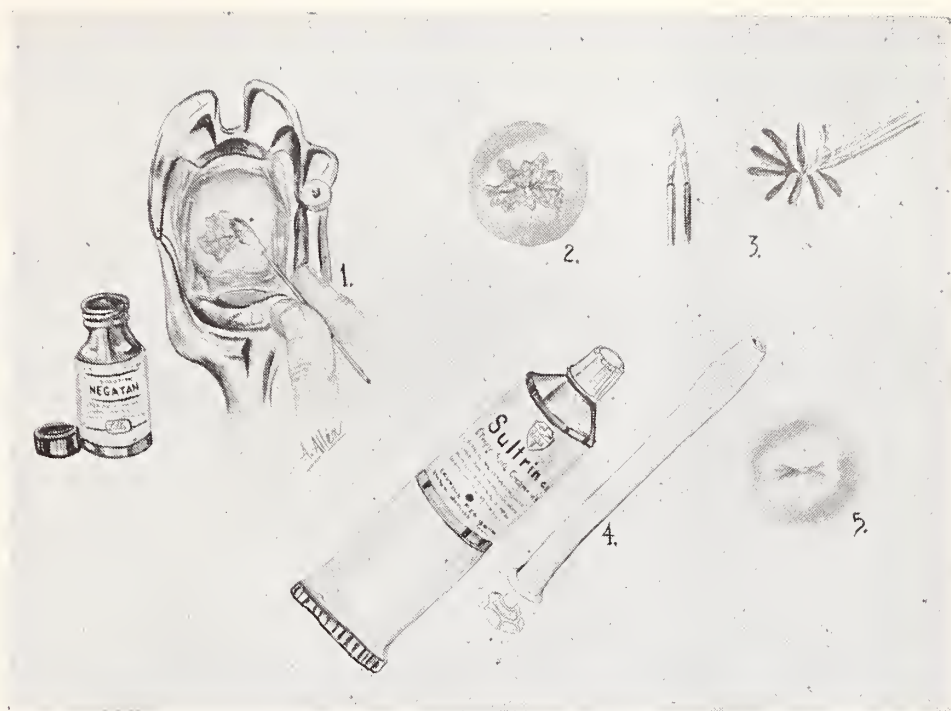


FIGURE 1
TREATMENT of cervicitis consists of the following: 1.) Cleansing with Negatan; 2.) achieving good exposure 3.) destroying the glands with deep cautery; 4.) following up with Sultrin and 5.) the healthy cervix.

describe above. One is not incapacitated by cervical cautery and the usual activities are permitted. Special medicine is used in the vagina to hasten healing. There may be some bleeding during the healing period but less than menstrual flow. A check-up examination two months later is wise.

It is important that the cautery be done immediately (one to three days) after the flow of a normal period stops. In this way there will be several days of healing before the next flow. Please call the first day of your menstrual flow to make your cautery appointment. In addition to the improvement of other complications previously mentioned, cautery has helped many women for whom marital relations have been difficult. Before applying cautery treatment, I check for cancer in all my patients over the age of twenty-five. Once a cervix is cauterized, it most likely remains healthy. No wonder I am an enthusiastic advocate for keeping the cervix clean and healthy.

The technic of office cauterization is as follows: The cervix is exposed and the mucus is removed with Nega-

tan. Linear cautery is implemented by the use of the National machine. The tip is heated until it glows and the entire involved portion deeply seared radially or spokewise. It is important to extend the spokes into the cervical canal to destroy the endocervicitis, as well as over the mucus glands on the ectocervix. The vagina widely opened with a large speculum, cleansing and drying the cervix as previously described, and taking one's time all lead to less pain and a cooperative patient (Figure 1). Written instructions should be given the patient following cauterization, as:

CERVICAL CAUTERY PLEASE READ AND FOLLOW THESE INSTRUCTIONS

1. Insert an applicator $\frac{2}{3}$ full of vaginal cream into the vagina at bed-time each night for two weeks. Wearing a pad is advisable.
2. Strenuous activity, any long trip over 100 miles, or intercourse may cause bleeding or pelvic pain the first four days following cautery, therefore, should be avoided.
3. Slight bleeding or spotting may

be expected following cautery, especially from the 10th to the 14th days. Sexual abstinence is wise again during this period.

4. *If bleeding is more than a menstrual flow or pelvic pain appears, call the office. Continue using the vaginal cream even though bleeding or having discomfort.*
5. *The next menstrual flow usually occurs according to its normal cycle, but it is not uncommon for it to appear earlier and last longer.*
6. *A check of the cervix should be made following the second or third period. Please make an appointment then.*

A check in two to three months following cauterization will, 99% of the time, satisfy you that the cervical lesion is eradicated. One good cauterization usually lasts a lifetime.

Benefits of Cauterization

The first benefit to be listed would be the removal of excessive vaginal discharge or leukorrhea. I believe that "possessing a wet bottom", having a foul discharge, carrying around a soaked vulva with unresponsive mucus is not desired by any woman. Too many are suffering needlessly in silence by thinking that excessive discharge is an expected part of being a woman or because they have been told they will outgrow it. Some mucus, especially that from the Bartholin glands or from the cervix at ovulation, is physiological and desirable.

The second benefit is the safeguard against vaginal and vulvar infections which would otherwise result from the alkalinity of the excess cervical mucus of cervicitis. Of 1,300 of my patients with vaginitis, 75% were associated with cervicitis. Patients fol-

lowed for an average of five years following cauterization had an incidence of 12%.

Third, higher fertility can result by removing the hostile mucus. The presence of cervical factors adversely affecting sperm motility and progression has long been postulated. Forty-five percent of 185 infertility patients (where tubes, sperm and ovulation were not at fault) conceived within nine months after cauterization.

Fourth, less pelvic inflammatory disease is found in the cases which have a cauterized or clean cervix. Seventy-nine percent of my 458 patients with pelvic inflammatory disease had cervicitis. These were women with pelvic pain and tender adnexa (without history and/or findings of endometriosis). Leukorrhea, low backache and dyspareunia may have coexisted. A recurrence of pelvic inflammatory disease is most unlikely in the healthy cauterized cervix. (A goodly number of patients suffering from dysmenorrhea have a "congenital erosion" and are helped by cervical cauterization.)

Fifth, the boggy infected cervix is no place for an intrauterine contraceptive device (I.U.D.) I am not really enthusiastic about any one contraceptive method. I have incriminated "the pill" as it has a multitude of unpleasant or deleterious effects. The diaphragm still has its place as does the I.U.D. but only in a healthy cervix. Not only is the I.U.D. held in place better with a healthy cervix but there is less spotting and ascending infection.

Lastly, but by no means least, the value of treatment by cautery is the prevention of carcinoma. "One cauterization in a lifetime would be greater protection to a woman than a Pap smear done twice annually." This

is a statement of the chief statistician of the American Cancer Society.¹

The basic solution to the major problem of cervical cancer is in its prevention. The solution does not lie in the treatment of the neoplasm nor with early detection by Pap tests or biopsies, but by destroying cervicitis. However, as a follow-up, the woman in my practice with a cauterized healthy cervix, without genital symptoms and a negative family history for cancer, now gets a Pap test once every three years.

The validity of my remarks in this discussion is based upon an I.B.M. computer analysis of case histories of my 10,500 patients who were classified as cervicitis cauterized, cervicitis not cauterized and those with a presumably healthy cervix. This study "Cervical Cauterization and Carcinoma of the Cervix"² was presented to the Central Association of Obstetricians and Gynecologists meeting in Dallas in 1962.

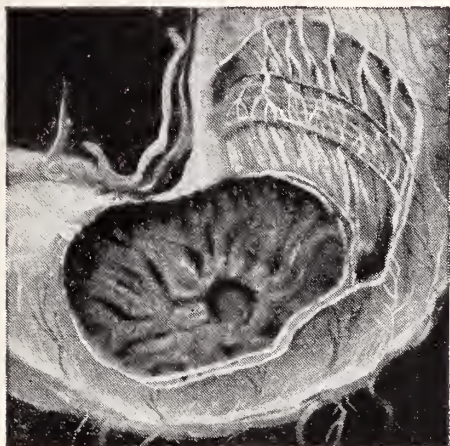
For the sake of summary, let us remember: Search for cervicitis by good exposure, cleanse with Negatan, destroy the glands with deep cautery, follow-up with Sultrin, and then be pleased, a few months later, with a healthy cervix.

I believe that greater emphasis should be placed on the cauterized cervix as a deterrent to the development of cancer. Less pelvic inflammation, less vaginitis, and improved fertility are likely when this simple office procedure is followed. Let us not overlook, ignore or fail to treat this common condition.

REFERENCES

1. Personal communications, Howard C. Taylor, Jr., M.D., President, A.C.O.G., 1962.
2. Peyton, Frank W., M.D.: *Amer. J. Obst. Gynec.* 86: 111-119, 1963. ◀

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED
COMBINATION
OF THE MOST WIDELY
USED ANTACIDS—
FOR RAPID
NEUTRALIZATION.
PLUS SIMETHICONE—
TO CONTROL
THE FACTOR WHICH
ANTACIDS ALONE
CANNOT INFLUENCE.

Mylanta[®]

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.



Amniocentesis, for the purpose of determining the severity of erythroblastosis, is a valuable and safe procedure when done carefully. Intrauterine transfusion may be useful if indicated by amniocentesis prior to the 33rd week of gestation.

Spectrophotometric Examination of Amniotic Fluid as a Means of Predicting Severity of Intrauterine Erythroblastosis

PAUL F. MULLER, M.D.
Indianapolis

ERYTHROBLASTOSIS due to Rh incompatibility has accounted for approximately five percent of recent perinatal mortality. Landsteiner¹, demonstrated the etiological factors in 1941 and in the latter part of that decade, treatment of affected neonatal infants by exchange transfusion was developed.² Despite almost universal acceptance and utilization of early induction and exchange transfusions in Indiana, perinatal mortality from erythroblastosis had shown very little decrease until about three years ago.

Since that time it has dropped about 43% (Figure 1), and has accounted for much of the drop in overall perinatal mortality during the same period (Figure 2). Whether this drop can be attributed to spectrophotometric examination of amniotic fluid is speculative as the number of examinations done in the state has been few—an estimated 500 procedures. It is probable that the drop is due to the use of the contraceptive pill by those iso-immunized women with poor obstetrical histories.

Past history and observations of serial antibody titers in the maternal blood have both been used as indications for early induction in severe cases. Neither has proven very reliable as an index of severity of the disease in the fetus.³ If the husband is heterozygous, there is a 50% chance that the infant will be Rh negative and

therefore unaffected. If the husband is homozygous, and the infants therefore all Rh positive, the infant is not necessarily more severely affected with each subsequent pregnancy.⁴ The fluctuation of the antibody titer is likewise very unreliable as an index of disease severity for in many cases it rises in the presence of an Rh negative, unaffected, infant; and on the other hand fails to rise above the original level in cases severely affected.⁵

These deficient indications have led to early induction, with the introduction of prematurity risk in unaffected babies, and also failure to induce in severely affected infants, with high perinatal mortality in both cases. A more accurate method of determining disease and the severity of it in the fetus was needed.

Amniocentesis

Observing the yellow discoloration of the amniotic fluid in affected cases, Bevis in 1952⁶ and Liley in 1961⁷ suggested a quantitative measurement of the decomposition products of hemoglobin in amniotic fluid by utilizing the 450 mu. peak in spectrophotometric examination of fluid obtained by trans-abdominal amniocentesis. This has proven to be a much more accurate indicator of severity of the disease and is now an accepted clinical procedure.⁸⁻¹³

A persistent antibody titer above 1:16 or 1:32 dilution after the 20th to 28th week, depending on past history, is an indication for amniocentesis. With a significant antibody titer, amniocentesis should not be withheld because all previous infants have been unaffected, as one third of all perinatal mortality occurs in the first affected pregnancy.⁴

Trans-abdominal amniocentesis may be performed on an outpatient basis and has been performed in one clinic over 5,000 times without serious maternal or infant morbidity.¹⁴ Before amniocentesis, the placenta should be localized by radioisotopes, x-ray, or ultrasonic technics. If the latter is utilized, the position of the fetus can be determined by palpation combined with vaginal examination if necessary. If position cannot be confirmed, an x-ray should be taken.

A site for aspiration is selected behind the fetal neck or in the region of the fetal small parts avoiding the placenta and fetal head at all costs. A #21 lumbar puncture needle is slowly inserted and 10 ml. of fluid aspirated. The amniotic fluid should be protected from light and refrigerated, but not frozen. It may be stored for several days. If the tap is bloody it may be centrifuged and utilized but an effort should be made to identify the blood as maternal blood or fetal blood from the intervillous space.

This is because fetal blood hemolyzes much more rapidly than maternal and can distort the spectrophotometric curve producing greater deviation at 415 to 420 mu. This becomes especially confusing because the amniotic fluid with severely affected fetuses in metabolic acidosis produces this same distortion.

If a recording spectrophotometer is not available, manual readings may be made at 10 mu. intervals and recorded on the semilogarithmic graph suggested by Liley (Figure 3). Readings from a recording spectrophotometer are more reliable in ruling out contamination from blood. The peak deviation at 450 mu. from the projection of the other readings is the significant figure. This is then plotted on the same graph against the period of gestation. A reading in Zone A indicates an unaffected infant but the test should be repeated closer to term. A reading in Zone B indicates a moderately affected infant. If the readings are high, they should be repeated at weekly intervals as the change to Zone C may be quite rapid. If the findings are in Zone C and confirmed and the specimen is not contaminated with blood, the fetus beyond 33 weeks should be delivered immediately by induction if possible, or if not, by cesarean section. If the same findings occur before the 33rd week, intrauterine transfusion is the procedure of choice. An example of a Zone C recording at 34 weeks is shown in Figure 3.

The technic of intrauterine transfusion has been described and will not be repeated here.^{11,15-20} The fetal mortality from the procedure is high and maternal infection has been reported.^{21,22} Hydrops fetalis has not been reversed and many will not attempt the procedure in the presence of hydrops.¹¹ Since many fetuses become hydropic quite early and it is technically possible to perform the procedure as early as the 18th to 20th week, titers and amniotic fluid should be checked early in mothers with poor histories. An intrauterine transfusion at 22 weeks may save an infant

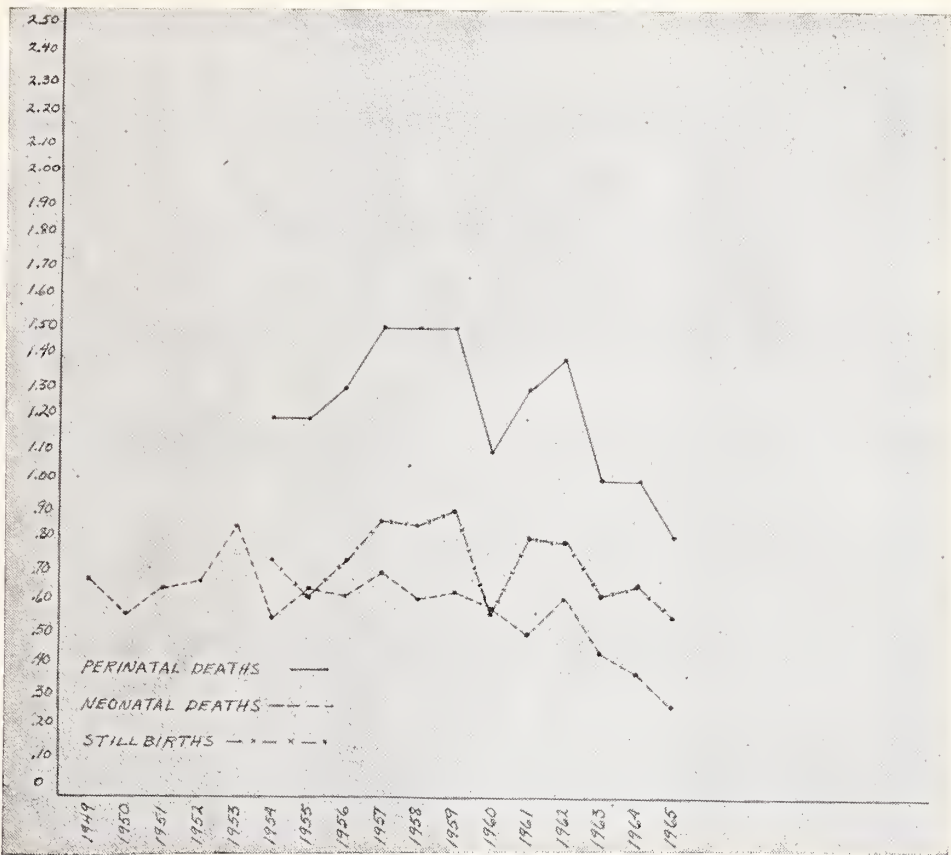


FIGURE 1
PERINATAL mortality due to erythroblastosis. (Deaths per 1,000 live births in the state of Indiana).

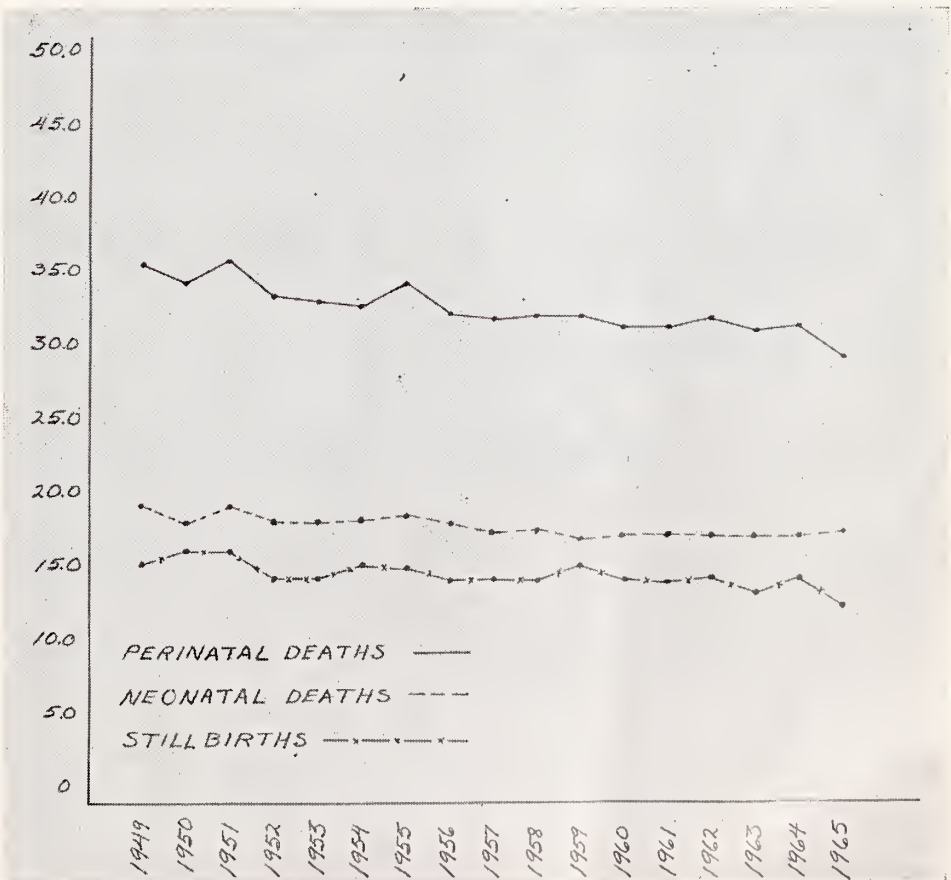


FIGURE 2
PERINATAL mortality. (Deaths per 1,000 live births in the state of Indiana).

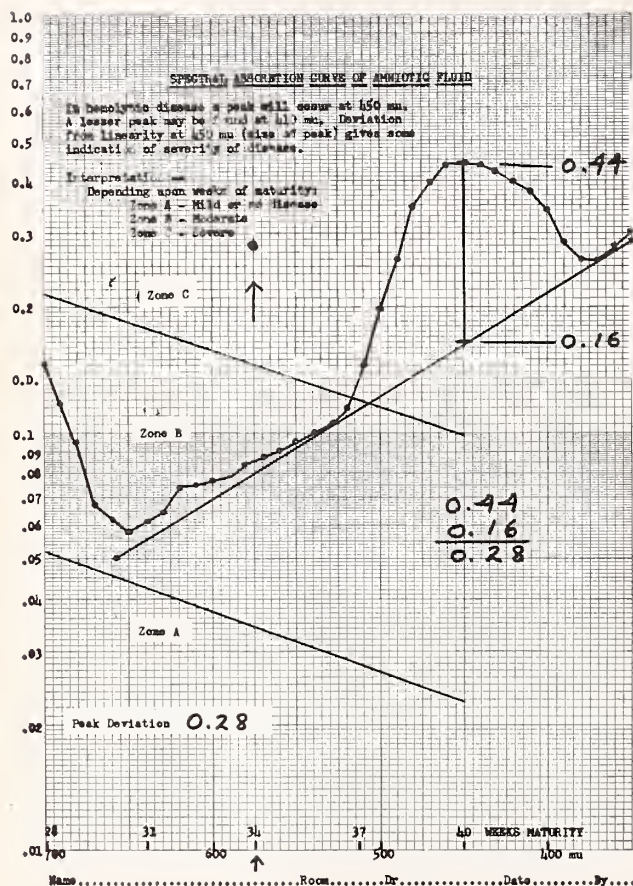


FIGURE 3
SPECTRAL absorption curve of amniotic fluid.

which would be hydropic a month later. Once started transfusions of increasing quantities should be given every 10 to 14 days until the fetus is mature enough for delivery.

Three cases of hydrops fetalis treated unsuccessfully and one case which required four intrauterine transfusions are presented.

Case Histories

Case #1—The patient, a 34-year-old para 4, gravida 5, was Rh negative; the husband homozygous Rh positive. The first two infants were living and well. She then had a hydropic infant which died in utero at eight months. The fourth was hydropic and died in utero at seven months.

In the present pregnancy in May, 1964, blocking antibody titers were positive 1:64 at 29 weeks and amniocentesis was performed. Serosanguineous ascitic fluid was obtained when amniocentesis was attempted and injection of dye confirmed the presence of the needle in the peritoneal cavity of the infant. The spectrophotometric examination of the fluid produced a

450 mμ. peak of .38; 150 ml. of ascitic fluid were withdrawn and 100 ml. of whole blood were administered. The fetal heart tones were lost the next day.

Case #2—The patient was Rh negative, Type O, and her husband Rh positive, Type A. She had had seven previous pregnancies. All previous babies lived and were Rh positive. The third infant required an exchange transfusion. The sixth was jaundiced but required no transfusion. The seventh required three exchange transfusions.

In the pregnancy between October and December, 1966, the Coombs was positive 1:1024 in the 27th week and amniocentesis was performed. The optical density deviation at 450 mμ. was 0.248.

Intrauterine transfusions were given as follows (Figure 4):

60 ml. packed cells were given at 27th week
 60 ml. packed cells were given at 29th week
 100 ml. packed cells were given at 32nd week
 120 ml. packed cells were given at 34th week

The membranes ruptured spontaneously ten days later and labor was induced after 24 hours with pitocin. The infant weighed 6 lbs., 1 ounce,

and had 16% fetal hemoglobin and 84% adult, therefore donor hemoglobin, by electrophoresis. It had a strongly positive Coombs test and a micro-bilirubin of 6.1 mg.%. The hemoglobin was 15.5 gms. These findings at birth in the infant born with 100% fetal hemoglobin would have been indication for exchange transfusion; but, because of the dilution with donor blood, it was elected to pursue a policy of watchful waiting (Figure 5). The infant was discharged from the hospital in excellent condition on the sixth day. An exchange transfusion was not required.

Case #3—This 27-year-old para 3, gravida 5, Rh negative patient was sensitized by blood transfusion after a tonsillectomy and adenoidectomy at age seven. The first baby was delivered at term and had four exchange transfusions. The second baby was delivered at 36th week by cesarean section and required five exchange transfusions. Since then she had had two miscarriages. In this pregnancy in December, 1966, the indirect Coombs was positive at 1:1024. In the 26th week of gestation, the amniotic fluid produced a 450 mμ. peak of 1.36 using a dilution factor. The infant was hydropic as aspiration pro-



FIGURE 4

CASE #2—Fourth transfusion. The thin needle is the impaling needle, the position of which has been checked by injection of 2 ml. of renovist. Opacities at marker #1 and #3 are previous sites of the transfusion needle which were not felt to be intraperitoneal. The transfusion needle above and to the right of marker "O" is definitely in the fetal peritoneal cavity with typical spread of the dye over the bowel.

duced 130 ml. of dark straw-colored ascitic fluid. This was withdrawn before 85 ml. of blood were administered. The fetal heart was lost the next day.

Case #4—The patient was a 32-year-old, para 2, gravida 4, Rh negative. The husband was homozygous Rh positive. The first infant was born in 1954 and was unaffected. In 1960, she had a spontaneous abortion at five months. In 1962, she had an affected infant which was hydropic and died after an exchange transfusion. In the present pregnancy in December, 1966, the indirect Coombs was positive 1:64 at 10 weeks and 1:512 at 17 weeks. At 26 weeks an amniocentesis was performed and the peak deviation at 450 mu. was .293. Intrauterine transfusion was performed four days later. The infant was hydropic as 130 ml. of dark ascitic fluid was found. The fetal peritoneal cavity was lavaged with Ringer's solution and 40 ml. of packed cells were given. The fetal heart was lost four hours after transfusion.

Although the second case had a peak deviation of 0.248 which is low in Zone 3, intrauterine transfusion was given without a second amniocentesis. The fact that at birth the infant's blood, which was only 16% fetal and therefore Rh positive, produced a micro-bilirubin of 15.4 mg. %, as shown, justified this decision made at the 27th week. None of the hydropic infants survived.

Current investigations indicate that administration of passive antibodies to Rh negative mothers who deliver Rh positive babies may prevent isoimmunization.^{23,24} This technic is being developed and will no doubt be clinically available soon. Erythroblastosis will not be a serious problem in the future. But, for the next 10 or 15 years, mothers will be delivering who were immunized before this protection was available. These mothers are the ones who will benefit from the technics described above.

Summary

1. Perinatal mortality due to ery-

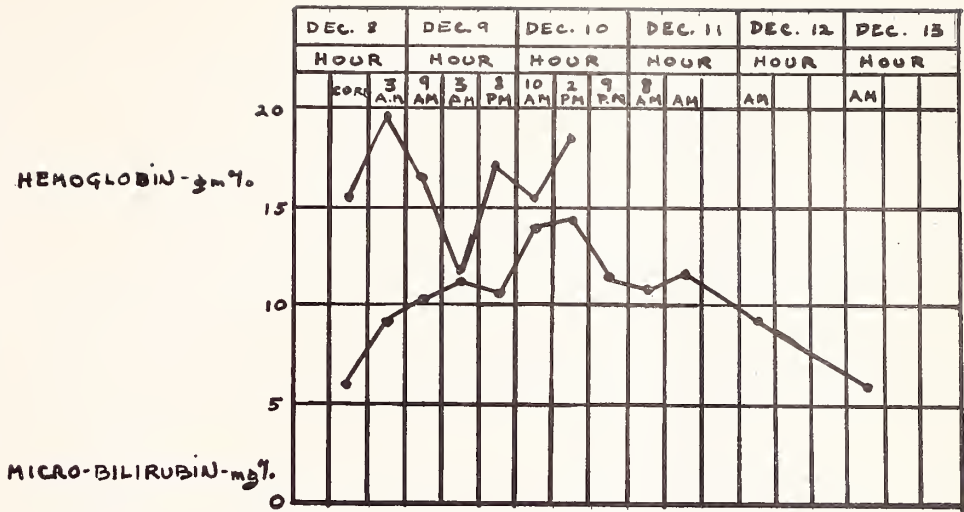


FIGURE 5
HEMOGLOBIN, micro-bilirubin levels.

throblastosis in the state of Indiana has decreased 43% in the past three years. It can be further decreased by the judicious use of trans-abdominal amniocentesis as a diagnostic aid.

2. All doctors administering prenatal care should be familiar with the indications for amniocentesis.

3. Amniocentesis should be done when titers above 1:16 or 1:32 dilution are positive. It should be performed as early as the 20th week in patients with a poor obstetrical history regarding erythroblastosis or at 28 to 33 weeks if a positive titer is the sole indication.

4. Patients with amniocentesis findings in Liley Zone 3 should be delivered if the gestation is beyond the 33rd week. Before the 33rd week, intrauterine transfusions may be administered.

5. Amniocentesis should be repeated at weekly intervals if findings are high in Liley Zone 2.

6. The administration of intrauterine transfusion is not without hazard to fetus and mother and should not be performed unless amniocentesis results indicate that the fetus would not survive without this procedure.

REFERENCES

1. Landsteiner, K., Wiener, A. S.: *Proc. Soc. Exper. Biol. and Med.* 43:223, 1940.
2. Diamond, L. K.: *Pediatrics* 2:520, 1948.
3. Editorial comment: *Lancet* 2:549, 1959.

4. Potter, E. L.: *Am. J. Obst. Gynec.* 75:348, 1958.
5. Novell, H.A., Taylor, P. W.: *Am. J. Obst. Gynec.* 82:1379, 1961.
6. Bevis, D. C. A.: *Lancet* 1:395, 1952.
7. Liley, A. W.: *Am. J. Obst. Gynec.* 82:1359, 1961.
8. Queenan, J. T., Adams, D. W.: *Obst. Gynec.* 25:302, 1965.
9. Crosby, W. M., Merrill, J. A.: *Am. J. Obst. Gynec.* 92:53, 1965.
10. Freda, V. J.: *Am. J. Obst. Gynec.* 92:341, 1965.
11. Westberg, J. A., Margolis, A. J.: *Am. J. Obst. Gynec.* 92:583, 1965.
12. Cherry, S. H., Kochwa, S., Rosenfield, R. E.: *Obst. Gynec.* 26:826, 1965.
13. Goldstein, P. J., Rosenstein, D. L., Bloomberg, G.: *Obst. Gynec.* 28:189, 1966.
14. Freda, V. J.: *Hospital Practice* 2:54, 1967.
15. Liley, A. W.: *Brit. Med. J.* 2:1107, 1963.
16. Queenan, J. T., Douglas, R. G.: *Obst. Gynec.* 25:308, 1965.
17. Creasman, W. T., Duggan, E. R., Lund, C. J.: *Am. J. Obst. Gynec.* 94:586, 1966.
18. Liggins, G. C.: *Obst. Gynec.* 27:617, 1966.
19. Liggins, G. C.: *Obst. Gynec.* 27:323, 1966.
20. Charles, A. G., Alpern, W. M., Friedman, E. A.: *Obst. Gynec.* 28:182, 1966.
21. Goodlin, R. C.: *Obst. Gynec.* 26:803, 1965.
22. 53rd Ross Conference on Pediatric Research, 1966.
23. Freda, V. J.: *Year Book of Obst. & Gynec.* 1966-67:275.
24. Schneider, J., Preisler, O.: *Obst. Gynec.* 28:615, 1966.

3440 N. Meridian St.
Indianapolis 46208

This is the third in a series of articles describing the cancer program at Indiana University School of Medicine as supported by the American Cancer Society.

The vital need for an effective therapy for the many different types of neoplastic diseases depends on progress made both at the bedside by the clinician and in the laboratory by the investigator. The advance in the fight against cancer is closely tied together with our understanding of the control of the functions of normal cells.

The Control of Biosynthetic Systems*

DAVID M. GIBSON, M.D.
Indianapolis**

THE starting point for any basic study on the etiology and control of cancer is a consideration of cell function—any cell. Although the accumulation of information on the nature of cells continues to grow exponentially, it is clear that all of the factors defining what a cell does (or



what a cell can do under unusual circumstances) is by no means completely understood. Everything a cell is, and everything a cell can do,

depends ultimately on the variety of protein enzymes it contains, which is the same as saying the enzymes a particular cell can synthesize. How enzymes act and how they are formed is central to the eventual understanding of what a cancer cell is.

Each chemical conversion in the cell is catalyzed by a unique enzyme. There are hundreds of different

enzymes in any cell. How they function in concert is one of the major considerations of biology today. Each enzyme is a member of one of many sequences of different enzymes. Since 1940 much attention has been directed to the isolation of enzymes and thereby defining what reaction each catalyzes and what chains of metabolic conversions take place in the cell. There are, for example, at least 21 enzymes responsible for the conversion of glucose to fat in liver (and adipose cells). The chemical intermediates at each step have been characterized. Many of the enzymes which make up a functional sequence are often associated together as a physical unit such that the intermediates do not become dispersed through diffusion. For this reason quite a few multienzyme systems are membrane bound. Membranes also serve to separate them from other events in the cell.

Molecular Structure

An important achievement of present day research is the description of the three dimensional structure of enzymes (as isolated in the pure state). The function of several enzymes can now be understood in terms of the molecular architecture of the active catalytic site on the protein. It is known that the shape

(conformation) of an enzyme (and its active site) can be altered by external conditions such that the catalytic activity of the enzyme is made greater or less. This implies that the function of many enzymes can be varied, *viz.* controlled.

Since every enzyme is a member of a sequence, increasing or diminishing the activity of one or several of the component enzymes can affect the productivity of the entire sequence. One of the limiting enzymes in the formation of fat from glucose in liver cells, which has been studied in our laboratory, may serve as an example. It is a biotin-containing enzyme called acetyl CoA carboxylase. If one determines the amount of this enzyme in liver tissue during a period of starvation, the level is found to be much lower than normal. If the experimental animal is fed a high-carbohydrate, low-fat diet the activity of this liver enzyme rises to very high levels, and fat (which was synthesized from glucose) begins to accumulate in the liver cells. One of the striking things about this enzyme is that it is inhibited by one of the later intermediate products of the multienzyme sequence, namely fatty acids (which can become part of the structure of fat, or triglyceride). This is a kind of negative feedback circuit, which promptly influences

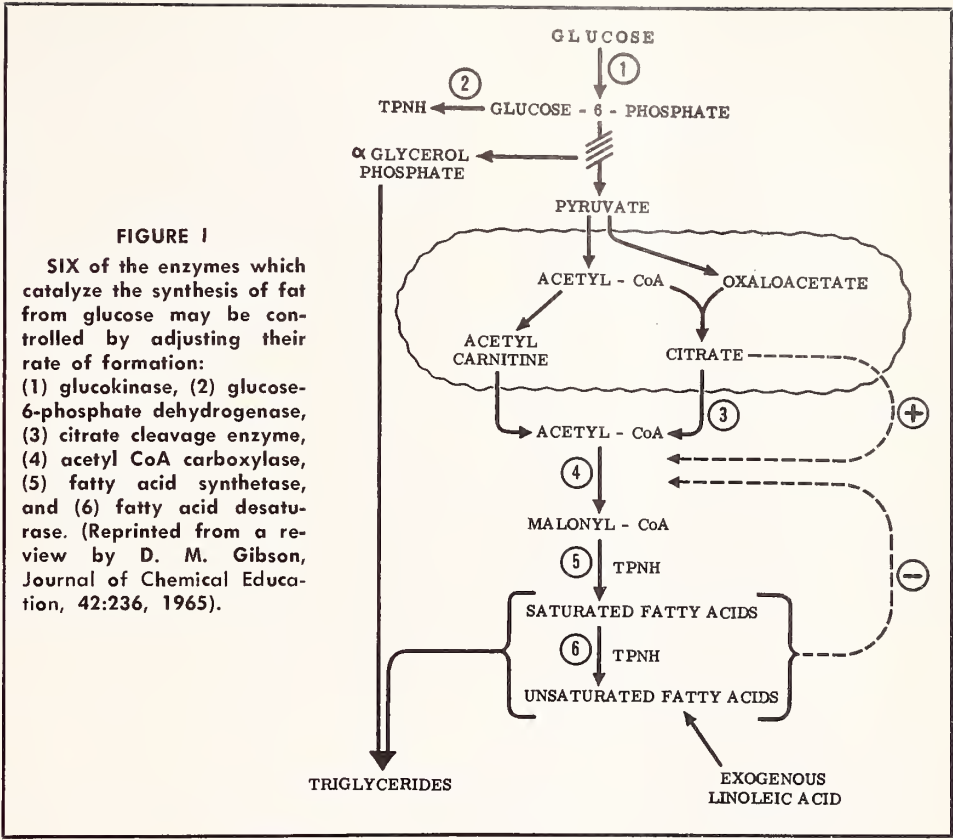
* Research project sponsored by American Cancer Society Grant P-178-H.

** Professor and Acting Chairman of Biochemistry, Indiana University School of Medicine, Indianapolis 46207.

the activity of enzyme already present in the cell. In starvation and following a meal containing fat, free fatty acids are in relatively high concentration in the liver. In these situations the necessity for synthesizing more fatty acids is strategically useless to the cell. Thus the signal to stop fatty acid formation is logical and is of advantage to the well-being of the cell.

Another important mode of control of the amount of enzyme in a cell is the fine adjustment of the balance between the rate of formation of the enzyme and its destruction. Studies in our laboratory indicate that the enzyme cited above rises to very high levels during carbohydrate alimentation, not only because the fatty acid inhibitor is diminished (since it is incorporated rapidly into triglyceride), but also because new enzyme is being synthesized. The signal to synthesize more enzyme is not well understood but it may be due to insulin (which is released into the blood during carbohydrate feeding).

In any event, the synthesis of new enzyme requires the intervention of the nucleus of the cell. A region along a strand of DNA in the nucleus must be signalled to initiate the synthesis of more messenger RNA of the kind which specifically directs the formation of the protein acetyl CoA carboxylase. The excessive synthetic process does not go on indefinitely, however. Forces are brought into play which now begin to limit net forma-



tion of this enzyme. Preliminary evidence has been obtained suggesting that enzyme destruction becomes greater as more enzyme is synthesized. Thus, a "proper" level of enzyme is restored, and the flow of glucose into fat is kept within bounds.

Enzyme Steps

The enzyme exemplified here is not the only enzyme to vary under these circumstances. Other enzymes which also play an important role in fat formation from glucose similarly are synthesized in response to high carbohydrate intake. Figure 1 shows six of these enzyme steps. It seems likely that a set of messenger RNA

molecules are issued by the nucleus which then govern the formation of this group of enzymes that are linked together in a common cellular activity.

All normal cells inherit these mechanisms of control which undoubtedly were advantageous from an evolutionary standpoint. There is now reason to believe that control patterns are defective in cancer cells, since ultimately growth and cell division rely on enzymes which catalyze the synthesis of all cell parts (including, of course, enzymes). Elucidating the nature of these control circuits is clearly prerequisite to an understanding of carcinogenesis and more effective therapy of the disease. ◀

The Case of the Mystifying Myelopathy

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

THE most recent medical graduates tend to look ever more condescendingly upon their antediluvian predecessors who obtained their M.D.'s in that rapidly receding era of the world floundering between the first two world wars. My late professor of pharmacology, Dr. Bernard Fantus, annually created a maximum of drama by bringing his "black bag" to class. He would empty it before our eyes displaying proudly the vials and ampoules he deemed useful. He placed enormous emphasis on the gap between what we saw and what was available to the "horse and buggy" doctor of the fin de siècle era.

My son has been a doctor only two years. More than 90% of HIS armamentarium consists of items discovered since the day Dr. Fantus was laid to rest! It is a near certainty that the year 2000 A.D. will make the second third of the century seem as outdated as 1930 appears to us now.

However, the *mystifying myelopathies* are still as baffling as ever — well, almost! Beriberi and pernicious anemia are killers no longer; B₁ and B₁₂ cure and prevent these nutritional disturbances with almost absurd ease. The neurophysiologists are probing in depth the macromolecular mysteries of nerve insulation, impulse transmission, short and long-term memory: they are even beginning to scribble a few tentative formulae for some substances. It is distressing to be told by MSD "Date-line in Science" (p. 3 of 12/16/66 issue) that no less than SEVEN new

"glycamino lipids" have been extracted from the human brain by doctors from the Boston University School of Medicine.*

We still do not comprehend a host of diseases baffling the clinicians. The neurologists can catalogue such abiotrophic, demyelinating, motor system afflictions as multiple sclerosis, syringomyelia and others. Is amyotrophic lateral sclerosis the paradigm for them all? American doctors, as represented in 11th edition of Cecil-Loeb, are inclined to say yes. The British authority writing in the 10th edition of Price separates amyotrophic sclerosis and thinks that the cause (when found) will be some enzymatic deficiency as exemplified by pellagra, beriberi and pernicious anemia.**

The authorities do agree in stating flatly that the etiologies are unknown and that there exists no treatment of any tangible value. There is the further confusion caused by not really understanding the membrane alterations that *are* seen. Just what does the glial cell proliferation signify? What role does the calcium ion play? (See symposium in FASEB Proceedings, Dec., 1966, Vol. 25, #6, Part I, p. 1804 on). While treatment remains a hope for the future—what is the meaning of the fascinating (coincidental??) parallel to the clinical sequelae of post-viral

* Lysozyme was discovered only within the decade; yet, the cover of "Scientific American" for Nov., 1966, displays the precise steric formula of the just how this enzyme destroys the bacterial wall. . . . Can the neurophysiologists emulate this feat?

** Read also:

1) *Neuromuscular Disorders*, Proceedings of the Association for Research in Nervous and Mental Disease, Williams and Wilkins Co., 1960.

2) "The Electromyogram," Fritz Buchthal, *World Neurology*, Vol. 3, No. 1, Minneapolis, Jan., 1962.

3) *Muscular Dystrophy in Man and Animals*, edited by G. Bourne and N. Golarz, S. Karger, Basel, Switzerland, 1963.

4) Presidential address, AAA of S, Henry Eyring, *Science*, Vol. 154, #3757, Dec. 30, 1966.



infections such as polio and encephalitis to say nothing of that great mimic, syphilis, of the CNS?? Where do "Gower's atrophy", "Charcot joints," etc. come in?

Debilitating Dysarthria

All this pundit palaver makes a perplexing preliminary to the tale of Helen S. The documentation is as exact as is possible at this time. Miss S. was born in 1919 into a superior, intelligent, upper middle class family. Her parents and one sister have had splendid health most of the time. Helen had a most uneventful childhood; the environment was happy; after high school, she became a top Hunter College alumna. At age 22, she entered the Yale School of Nursing. In the fall of 1942, she had a severe bout of URI; this is mentioned only because, in later years, the possibility of this having been an unrecognized attack of poliomyelitis was raised. In any case, shortly thereafter, Helen began to have progressively more severe speech difficulties. There was rapidly worsening involvement of cranials XI and XII: the bulbar disease slurred speech and made deglutition a hazard. At the infirmary, the diagnosis of *amyotrophic lateral sclerosis* was made. By Dec., 1942, she was invalided and admitted to the Neurological Institute of New York City. The impression was, "rapidly progressive, bulbar form of A.M.L.S." Bravely, Helen

attempted to finish her training. However, by mid-1943, all four extremities had become so weakened that she had to leave the school.

Metabolic Manducation

By 1944, bulbar progression had slacked off even as the peripheral spread was rendering Helen more helpless. Dr. I. Wechsler re-admitted her again to Mt. Sinai Hospital; the grim diagnosis was reconfirmed. At this time, Helen and her parents turned to an unorthodox practitioner who shall be nameless. He placed her on a very strict, supervised diet. Essentially, it consisted of fruits and vegetables, chiefly in the raw state, plus an ounce of pre-digested protein with each meal. She received cheese from skimmed milk even as eggs, meats, fish and bread were excluded! Helen was also placed on graded gymnastic exercises: 10 minutes on with five minutes rest: two hours twice a day. The wattage measurements of the expended energy are not known. Attention should be called to the well known fact that present day Olympic athletes undergo such training. Energy reserves CAN be built up to a truly astonishing extent!!

Helen worked hard and faithfully at this program. She was fully aware of her prognosis: this seemed to offer both an escape and a promise. By 1946, she had lost some 30 pounds as compared to her pre-illness weight. However, she *felt* much better and KNOWS that she had more strength and mobility than before the year spent on this regimen! That fall, Dr. Wechsler saw her again and restudied the entire situation. He noted the obvious arrest of the clinical symptoms and signs. He commented specifically on the unusually lengthening life span "because of its rarity."

Helen was — and remains — convinced that the year spent on this program *cured* her! "I stopped getting worse and even became somewhat better!" This was in 1946! By 1952, Helen was neither better nor worse. She was admitted to a chronic diseases facility where she has re-



mained ever since! As I am writing this in 1967, it is clear that Helen's disease has been in remission for no less than 25 years. Her amyotrophic lateral sclerosis has failed to progress as Helen has stayed in reasonably good health all this time. There is no record of "Lou Gehrig's disease" having been contained for so long a time!

Indesinent Interregnum

The attending neurologist has been following Helen's case for the last 14 years. He can find no essential alteration in her status. Her mentation is as good as ever. The EEG's are all normal as is the spinal fluid. "Patient can stand with assistance . . . motor neuron involvement is as prominent as at all other times. . . . The thenar and hypothenar atrophies remain marked. . . . There are no sensory changes . . . chest musculature markedly atrophied: visible fibrillatory twitchings. . . . Patellar, Wartenberg and Rossolimo signs all positive. . . ."

(The patient was kind enough to furnish me with a photograph of herself taken just before her illness. Also, she has posed for a photograph I took of her in her wheelchair. In this picture, her hands are prominently displayed to show their musculature.)



Pulmonary function tests, performed in 1966, showed a reduction to only 20% of normal. For assisted coughing, she is continuing with her breathing apparatus. However, she can sit up without a corset or any back support. Whether due to her rehabilitation therapy or not, her leg muscles seem to be stronger than at her admission in 1952. The equinovarus of her feet is being corrected with special surgical shoes and braces. She can extend both feet simultaneously against gravity.

So, in briefest summary, we are presenting the longest recorded remission in an abundantly proven case of amyotrophic lateral sclerosis. I believe that there are no discernible genetic or infectious factors that precipitated the disease.* Most intriguing, there is this most analytical, keenly intelligent patient's absolute conviction that the bizarre diet AND

* Hirano, A., Kurland, L. T., Sayre, G. P.: Familial Amyotrophic Sclerosis, *Arch. Neurol.* 16:227-238, March, 1967. These authors come out unequivocally for the familial causation of the disease. They classify AMLS as (1) classic or sporadic, (2) familial and presumably hereditary, (3) the Marianas Islands form.

Another strong argument for the genetic etiology concept is that the disease is so common among the Chamorros of the South Pacific.

the strenuous gymnastic regimen of 1945-46 was (and is) the direct reason for the arrest of the usually swift, inexorable progression that is a hallmark of "Lou Gehrig's disease." For

20-odd continuing years??? Who can disprove this "post hoc, ergo propter hoc" reasoning??

Let us merely record the facts and defer all sermonizing until AFTER

the happy day when the true etiology of amyotrophic lateral sclerosis will have been elucidated. ◀

1270 Fifth Ave.
New York, N. Y. 10029

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1967 annual meeting of the Indiana State Medical Association, Oct. 9-12 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Ray H. Burnikel
517 Sycamore St.
Evansville

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

Posterior Dislocations of the Shoulder

GEORGE F. RAPP, M.D.
Indianapolis

POSTERIOR dislocation and fracture dislocation of the humerus from the glenoid are two entities often misdiagnosed by the physician. Delay in diagnosis and treatment causes irreparable damage to the shoulder joint. Since the clinical history, physical findings and roentgenographic evidence are rather classic, this entity is being included in this series.

In the last two years we have treated four patients with posterior dislocation of the shoulder. Case I occurred in a hospitalized chronic epileptic who was purposely thrown into a convulsion while undergoing diagnostic EEG studies. Case II occurred in an alcoholic hospitalized for delirium tremens. This dislocation was missed on an AP and trans-thoracic view and first treated seven weeks later. Case III was a gymnast who had been exercising on parallel bars. This dislocation occurred 18 months previously and was of the recurrent type. Case IV occurred in a patient who developed seizures secondary to chickenpox encephalitis.

In three of the four cases reported here, the diagnosis was missed by the first physician who saw the patient. This is more commonly missed in posterior dislocations associated with fracture. In the cases reported in the literature, about one-half were not recognized until several weeks or months after their injuries. This error

would be less common if all physicians were suspicious of posterior dislocations in: 1.) all patients with shoulder pain after convulsions; 2.) patients with shoulder pain after shock therapy; 3.) patients who do not respond well after "minimal" shoulder fractures; 4.) all patients with "frozen" shoulders after trauma; 5.) all patients who undergo severe trauma to the flexed, adducted and internally rotated arm; 6.) all patients who undergo a direct trauma to the anterior shoulder; and 7.) all patients who have a "clicking" or feeling the "shoulder is going out of joint."

Recurrent posterior subluxations and dislocations of the shoulder may occur after little or no history of trauma. Muscle imbalance is present and the patients can often spontaneously sublux and reduce the shoulder by flexing, adducting, and internally rotating the shoulder. Occasionally patients in this group have undergone surgery for recurrent anterior dislocations, only to have it noted later they were posteriorly dislocating their shoulders.³

Physical Findings

When the physician sees a patient with a posterior dislocation, the shoulder is generally markedly swollen due to the blood beneath the deltoid muscle. The patient holds the arm in a position of marked internal

rotation. If the swelling is not too severe, as very early or later after the acute stage has passed, a loss of anterior roundness to the shoulder and a fullness posteriorly may be noted. The coracoid and anterior portion of the acromion are prominent. The patient generally has little or no active glenohumeral motion and passive motion causes pain. The arm cannot be externally rotated. Neurological and vascular complications are less common than in anterior dislocations.

Roentgenographic Findings

On an AP view of a normal shoulder, the greater tuberosity stands out laterally in profile. The lower one-third of the glenoid is covered by the articular portion of the humerus.

On the AP view of a posteriorly dislocated shoulder of the subglenoid or subspinous type, the humerus is in extreme internal rotation. The profile of the greater tuberosity is lost; the lesser tuberosity forms the medial border of the roentgenographic shadow of the humeral head, and the lower one-third of the glenoid may be exposed^{4,5,8} (Figure 1). However, many of these findings may be present in a shoulder in internal rotation in a sling or Velpeau dressing. Posterior dislocations may also be in a subglenoid position.³ These appear very similar to anterior dislo-



FIGURE 1

AP VIEW. Note loss of profile of the greater tuberosity and the lesser tuberosity forms the medial border of the humeral head.

cations on the AP view.

A good axillary view is a must before a posterior dislocation of the shoulder can be completely ruled out. We have been able to obtain these in all cases if the physician assisted the technician in positioning the patient (Figure 2). Should the movement be too painful, an oblique view in the axis of the spine of the scapula will aid in showing the dislocation.¹ Stereoroentgenograms, transthoracic views and obliques to "open up the joint line" are often helpful if they prove positive. However if the latter views are poorly taken or misinterpreted, they will only leave the physician with a false sense of security, prolong treatment and greatly decrease the chances for a satisfactory end result.

Treatment and Prognosis

In acute posterior dislocations and posterior dislocations with minor fractures diagnosed early, a satisfactory treatment plan is: 1.) gentle reduction under general anesthesia; 2.)

maintaining position in a spica cast for three or four weeks or using the cruciate wire method of Wilson and McKeever in selected cases; 3.) gradual rehabilitation with exercises. In these cases the results are generally good to excellent. If the shoulders are unstable, further surgery is necessary.

The end results in neglected cases of posterior, habitual and constant dislocations are generally in proportion to the time elapsed after injury.¹ In Case II seven weeks had elapsed after injury. The patient was treated by closed reduction and cruciate wire fixation from the acromion to the humerus⁷ for four weeks, as the shoulder was unstable without internal fixation. This patient obtained a good result. Many neglected cases require open reduction. In these cases McLaughlin's subscapularis transfer gives good results.² In the older age groups, some neglected cases have obtained a functional shoulder and may not require or may refuse open reduction.

In cases of spontaneous recurrent subluxation and dislocation posteriorly, as in Case III, a posterior bone block with capsular plication is generally considered the treatment of choice.² Posterior capsular repairs or Bankart-type procedures have been reported where the pathologic condition warranted their use.³ Recently Scott reported three cases treated by osteotomy of the posterior glenoid.⁶ Subscapularis transfer is ineffectual in recurrent subluxations.²

Summary

Posterior dislocation and fracture dislocation of the shoulder are entities too often missed by physicians. Delay in diagnosis causes irreparable

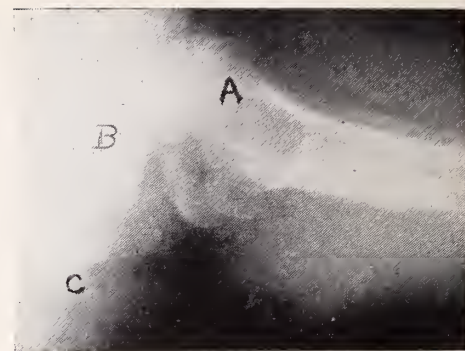


FIGURE 2

A-humerus, B-glenoid, C-coracoid. The posterior fracture dislocation is readily apparent.

joint damage. Four new cases of posterior dislocation are presented, the clinical history, physical findings, roentgenographic diagnosis and treatment are reviewed.

REFERENCES

1. McLaughlin, H. L.: Posterior Dislocation of the Shoulder, *J. Bone and Joint Surg.* 34-A:584, 1952.
2. McLaughlin, H. L.: Posterior Dislocation of the Shoulder, (Follow-up notes) *J. Bone and Joint Surg.* 44-A:1477, 1962.
3. Nobel, W.: Posterior Traumatic Dislocation of the Shoulder, *J. Bone and Joint Surg.* 44-A:523, 1962.
4. Rendich, R. A.: Roentgen Diagnosis of Posterior Dislocation of the Shoulder, *Radiol.* 36:42, 1941.
5. Robertson, R., Stark, W. J.: Diagnosis and Treatment of Recurrent Dislocation of the Shoulder, *J. Bone and Joint Surg.* 29:797, 1947.
6. Scott, D. J.: Treatment of Recurrent Posterior Dislocations of the Shoulder, *J. Bone and Joint Surg.* 49-A:471, 1967.
7. Wilson, J. C., McKeever, F. M.: Traumatic Posterior Dislocation of the Shoulder, *J. Bone and Joint Surg.* 31-A: 160, 1949.
8. Wood, J. P.: Posterior Dislocation of the Head of the Humerus and Diagnostic Value of Lateral and Vertical Views, *U. S. Nav. Med. Bull.* 39:532, 1941.

508 Hume Mansur Bldg.
Indianapolis 46204

“Take a laxative” is a harsh sentence

Although there are more than 60 ethical laxatives available for the constipated patient, many, unfortunately, do not really produce an effect much like a normal bowel movement. Instead they whip the bowel, torment it and leave it irritated, inflamed and exhausted.

On the other hand, Dulcolax

provides a nearly normal movement. Through its unique contact action, it induces the kind of natural contraction waves of the colon necessary for gentle, complete, comfortable bowel movements.

For your next constipated patient, try Dulcolax—the laxative with the gentle touch.

Dulcolax, brand of bisacodyl tablets (5 mg.)

Under license from
Boehringer Ingelheim
G.m.b.H.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York

Dulcolax® a gentle persuasion

Geigy

The AMBAR
SCRAPBOOK
of

Obesity Oddities

FACT & LEGEND

CHARLES
DICKENS'

"FAT BOY JOE"

in Pickwick Papers

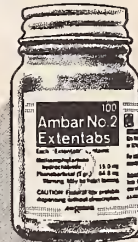
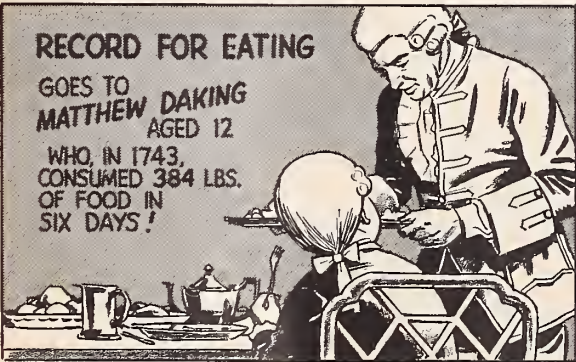
IS THE FIRST RECORDED CASE OF
OBESITY WITH NARCOLEPSY

DR. C. SIDNEY BURWELL COINED THE
TERM "PICKWICKIAN SYNDROME" IN 1955!



RECORD FOR EATING

GOES TO
MATTHEW DAKING
AGED 12
WHO, IN 1743,
CONSUMED 384 LBS.
OF FOOD IN
SIX DAYS!



The Cost of AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

AMBAR #2 EXTENTABS®

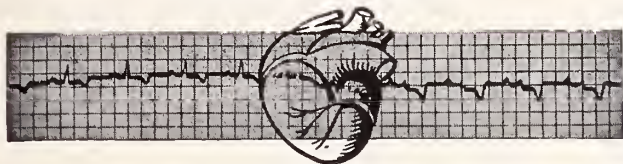
methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H ROBINS

Electrocardiogram of the month



Presented as a regular feature of *The JOURNAL*, *Electrocardiogram of the Month* is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Pulmonary Emphysema vs. Myocardial Infarction

CHARLES FISCH, M.D.
Indianapolis

AS was pointed out in an earlier "ECG of the Month," the electrocardiogram of pulmonary emphysema may at times resemble that seen in myocardial infarction.

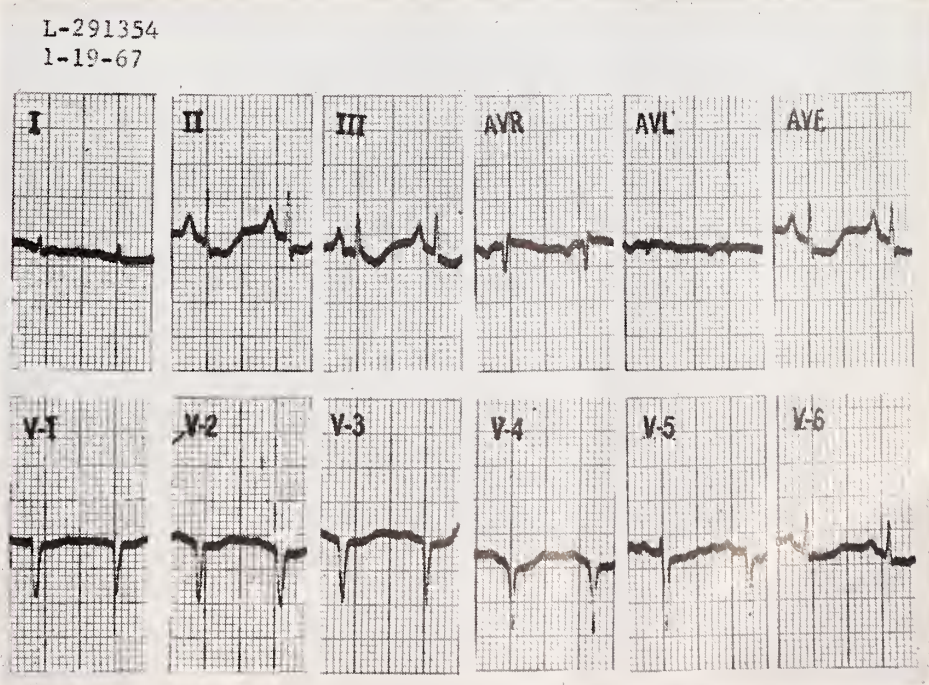
The tracing reproduced in Figure I has some of the features of both, namely that seen in emphysema and

myocardial infarction. The findings usually ascribed to emphysema include prominent P waves with right axis deviation of the P waves (about $+90^\circ$) and prominent Ta segment, vertical position, marked clockwise rotation and low voltage of the QRS (R in V-6 <7 mm). The feature

strongly indicative of myocardial infarction is the poor progression of the R wave from V-1 to V-5 with QS waves in V-1 to V-4. The final decision as to whether the patient has emphysema and myocardial infarction or emphysema without infarction but with a pattern simulating infarction is a clinical one. ◀

FIGURE I

THE diagnostic features of emphysema include (1) prominent P waves in II, III and AVF, (2) right axis of the P waves, (3) prominent Ta segment, (4) clockwise rotation and (5) low voltage of QRS. Features of myocardial infarction include the QS patterns in V-1 to V-4.



X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

The Arteriographic Diagnosis of Periarteritis Nodosa

ERICH K. LANG, M.D.
Indianapolis*

A 56-year-old white female was observed for the past nine months for complaints of diffuse muscular pain related to febrile episodes, malaise and migratory joint pain. Physical examination was unremarkable with the exception of a markedly elevated blood pressure of 180/120 mms., confirmed on several occasions, and hepatosplenomegaly. There was no evidence of cutaneous hemorrhages; the joints appeared to be unremarkable on gross assessment.

The laboratory work-up revealed what appeared to be a secondary anemia. Renal function studies and blood-urea-nitrogen levels were normal. Roentgenographic studies, consisting of chest roentgenograms, an upper and lower GI series, a gallbladder series and intravenous pyelograms, as well as roentgenograms of most major joints were unrevealing with the exception of demonstration of left ventricular accentuation of the heart shadow.

A renal arteriogram, performed for assessment of the cause of hypertension, raised the question of micro-aneurysms of the tertiary intrarenal vessels. A selective arteriogram of the superior mesenteric artery demonstrated, in classical fashion, multiple micro-aneurysms of the peripheral branches of the superior mesenteric artery (Figure I).

* Radiologist, Methodist Hospital, Indianapolis 46207.

The diagnosis of periarteritis nodosa was confirmed by skin biopsy.

Comment

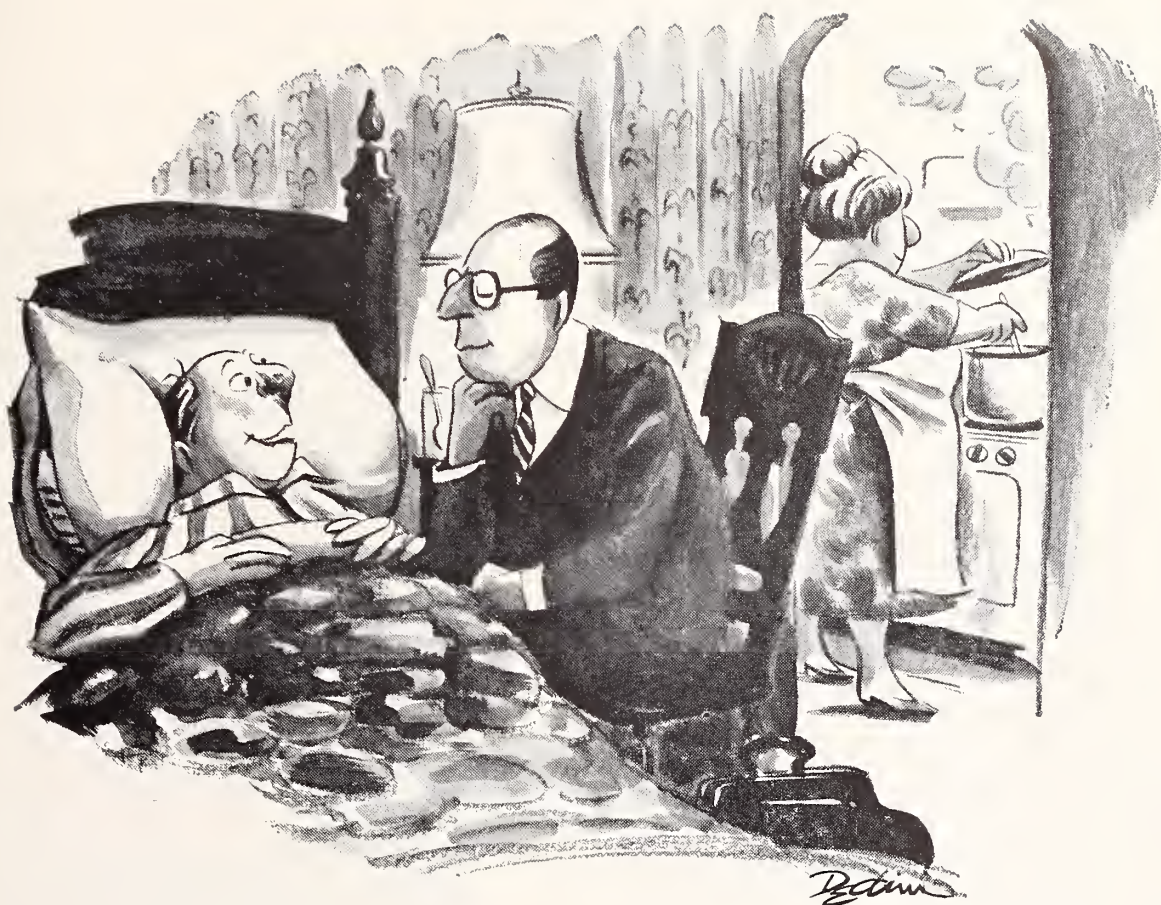
The characteristic demonstration of micro-aneurysms, best demonstrated by selective arteriography of the superior mesenteric artery, is considered diagnostic for periarteritis nodosa. Similar micro-aneurysms are frequently seen in the peripheral branches of the renal arteries and

may be encountered in the splenic or hepatic arterial bed.

Selective arteriography of one organ system is preferred because it allows detail assessment of the vascular bed and optimal roentgenographic presentation. Flush arteriograms demonstrating the same pathology are more difficult to interpret because of overlying opacified vascular structures of other organ systems. ◀

FIGURE 1
TYPICAL micro-aneurysms of the tertiary radicles of the superior mesenteric arterial supply are demonstrated on this selective arteriogram of the superior mesenteric artery. The demonstration of micro-aneurysms is considered diagnostic of periarteritis nodosa.





*"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."*

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

The Cancer You View

Edited by

Edwin E. Pontius, M.D.

Indianapolis*

A 62-year-old woman had experienced frequent episodes of watery diarrhea with mucus for two years. Three months previous to hospitalization, she noted a small amount of blood in the stool. Digital examination failed to reveal any mass or stricture. Roentgenographic studies were performed with evidence of a filling defect at the rectosigmoid level but were considered doubtful because of poor preparation of the bowel. This is a simulated sigmoidoscopic view of the inferior margin of the lesion.

What is your diagnosis?

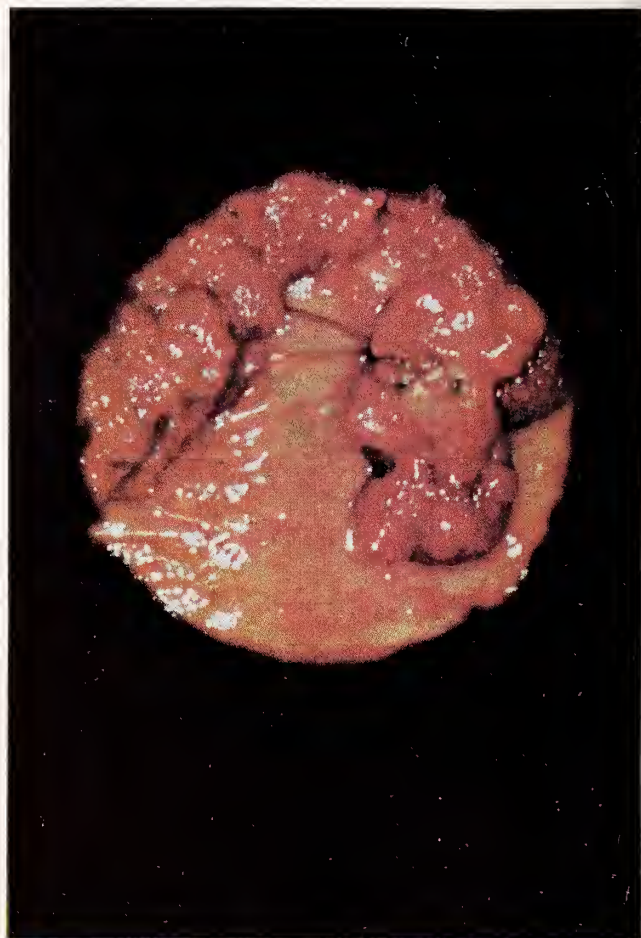
What diagnostic procedures would you recommend?

What therapeutic procedures would you consider?

For diagnosis and discussion, please see page 961.

* From the Pathology Section, Methodist Hospital of Indiana, Inc., Indianapolis 46207.

Supported by the academic activities and financial assistance of the Methodist Hospital Graduate Medical Center and the American Cancer Society, Indiana Division, Inc.



INDIANA MEDICAL BUREAU

816 Hume Mansur Bldg.

634-5804

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 16th Year Of Service

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46208.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth
Street, Terre Haute; Lall G. Montgomery, M.D.,
Ball Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:

Term Expires

Harold D. Lynch, M.D., Evansville Dec. 31, 1967

Jene R. Bennett, M.D., South Bend Dec. 31, 1967

Alvin J. Haley, M.D., Fort Wayne Dec. 31, 1968

Wei-Ping Loh, M.D., Gary Dec. 31, 1968

Jack W. Hickman, M.D., Indianapolis . . . Dec. 31, 1969

Frank H. Coble, M.D., Richmond Dec. 31, 1969

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Hospital Supply Sales up, Up, UP

RAPID expansion of the hospital supply industry is predicted by a recent industry report by Burnham and Company, of the New York Stock Exchange. It is expected that annual sales will double between now and 1970 and at that time will equal \$3 billion.

The Burnham analyst estimated that hospital costs will increase by 20% during the current year. He points out that due to higher minimum wages and the move to unionization, many hospitals will be compelled to adopt efficiency measures. Since most hospitals now function in an archaic and obsolete manner, the necessary modernization will present challenges and opportunities to the hospital supply industry.

Hospital construction expenditures are also expected to double by 1970. The provision of minimal bed requirements now requires \$2.5 billion annually; the estimate for 1970 is \$5 billion per year.

About one-third of the 750,000 short-term general hospital beds are now obsolete. Modernization will cost almost \$30,000 per bed and at this rate, more than \$7 billion is needed just to maintain the status quo.

The use of outpatient clinics is increasing by approximately eight percent per year and expenditures for medical research are up by 10% annually; both developments increase the need for hospital supplies.

While the move to disposable supplies was initiated because of the high cost of cleaning, packaging and sterilizing standard equipment, a secondary benefit has been realized, in that judicious disposal of contaminated disposable supplies is resulting in less cross-infection. Burnham estimates that more than \$100 million worth of disposable kits will be sold in 1970—about three times the present volume.

Population growth, the greater public awareness of health problems, increasing expenditures for medical care and the rising utilization of medical institutions are cited as the basis for the above predictions.

Intrauterine Transfusion

INTRAUTERINE transfusion is an innovation which has moved the frontier of medical knowledge and aroused widespread enthusiasm. The entire subject of erythroblastosis fetalis, its etiology and management is thoroughly discussed in this issue of *The Journal* by Dr. Paul Muller

of Indianapolis (pp. 914-917).

Exchange transfusion of the newborn for hemolytic disease has been successfully practiced for a number of years. This procedure, along with advances in diagnosis, has reduced the death rate by about two-thirds during the past ten years.

Newer approaches are now being made to control the disease before birth. Spectrophotometric analysis of the amniotic fluid, as described by Dr. Muller, provides much information concerning the condition of the fetus and serves as a guide for further management.

Intrauterine administration of red cells into the peritoneal cavity of the fetus, the removal of antibodies from the immunized mother's blood by plasmaphoresis and the prevention of antibody formation in the mother—although still under investigation—offers promise of eradicating the disease or at least of obtaining a viable infant at birth.

Most severe cases of erythroblastosis fetalis are caused by sensitization of the Rh-negative mother to the Rh (D) blood factor. The prevention of isoimmunization of the Rh-negative mother has attracted serious attention. It is based on the well-known principle of immunology that the pas-

sive administration of antibodies will block the active formation of like antibodies. Immunized Rh-negative mothers are given a specialized gamma globulin preparation containing a high level of Rh antibodies immediately (within 72 hours) following delivery of the first Rh positive infant. The results of this procedure at the Columbia Presbyterian Medical Center are particularly promising.

When it is reasonably suspected from the patient's obstetrical history of isoimmunization, blood titer and the examination of the amniotic fluid that the fetus is severely affected, intraperitoneal or intravascular injection of blood offers hope of obtaining a viable infant. Since Liley first described the procedure from New Zealand in 1963, there have been many reports of successful administrations of red cells to the fetus.

The steps in the procedure are essentially: (1.) the position of the fetus is determined by injection of an opaque substance into the amniotic fluid and by stereoscopic examination with image intensification and television monitoring; (2.) a six inch, 20-gauge Touhy needle is inserted into the peritoneal cavity of the fetus; (3.) a plastic tube is inserted thru the needle to allow for movement of the fetus; (4.) packed red cells are injected through the needle or the insert.

The injections are usually attempted between the 30th and 34th week of the pregnancy, although they may be done earlier and may be repeated. This is a highly technical procedure. Hepatitis has been reported in the mother and premature labor has been induced. In rare cases blood has been injected into the fetal pleural and pericardial cavities and the bladder. Amnionitis and peritonitis have also been complications, and unexplained fetal deaths have occasionally occurred. The survival rate for transfused infants has been reported from 30 to 50%; the primary fetal mortality

of the operation has been estimated at about 12%.

There have been several modifications of technic for transfusing the fetus. Intrauterine exchange transfusions have been done by opening the uterus, withdrawing a leg and using the saphenous vein for the replacement transfusion. The examination of the blood of infants following intrauterine transfusions shows the majority of cells to be of the injected adult type, proving the effectiveness of transfusion of cells even into the peritoneal cavity of the fetus.

The salvage of some infants who previously would have been considered hopeless warrants further study of this highly complex procedure. It would be unrealistic to expect to save all infants with hemolytic disease. In medical centers where facilities and skills are adequate, where time and study can be given to each case and with rigid selection of cases, it is a procedure worth further investigation; but it is still in the investigational state and is not a routine clinical procedure. Intrauterine transfusion is not indicated in cases where the fetus is expected to survive until delivery by induction of labor or section.—**David A. Bickel, M.D., South Bend.**

The Old Grouch Fights Back

WHEN we left the old grouch, all were assured that he was bowed and beaten. At least four formidable arguments were raised against his plan to decrease the number of residency programs in the United States from 39,000 to 10,000. He was quick to point out that his proposal's strongest basic defense was that it would upgrade both general and specialty practice in the country, in addition to its main impact of increasing the number of general practitioners.

To the arguments that his plan is basically dictatorial and would deprive some medical students of their unalienable rights to become neurosurgeons, he replied "poppycock!"

Amplifying on this, he stated that the majority of people entering medical school still want to become physicians and take care of sick people. Only a minority of these students have preconceived ideas about a preference for specialty practice.

Waxing philosophical, he continued, "If a segment of society (physicians) is to receive preferential rewards (financial, esteem, leadership, etc.) because of society's need for the product (health care) their segment has to offer, then it becomes obligatory upon this segment to deliver the goods." If society has charged American medicine to bring an adequate number of capable practitioners to it, it will sooner or later expect results; and presently, it is not too pleased with what it has purchased. A young man or woman entering a profession that avows service must expect to serve.

The old grouch was quick to admit that both community hospitals and university medical centers would attack his plan, but for different reasons. With far fewer residents and fellows around, the physicians in charge of a sick person would have to take more care of the patient personally. This, our friend says with candor, is exactly what he had in mind as another beneficial side-effect of his proposal.

His plan would not limit training of residents to university medical centers alone. Many programs would still be in community hospitals, and those that remained would have a far better prospect of filling their positions with first-class applicants. The alleged "feather-bedding" of huge medical center residency programs would be restricted severely.

Our friend even offered, with no charge, the opinion that the AMA residency review committee could conduct more meaningful inspections if it had only one-fourth as many programs to inspect. I was forced to agree.

Actually, he presents a very tempting, forceful and seemingly

sound case. As he left, he whispered one sound objection to his plan that we hadn't mentioned, but he made me promise not to reveal it. Perhaps he will relent at a later date.—J.W.H.

Guest Editorials

Medicare—Diagnosis and Treatment

THE Denver Medical Society at its meeting of March 7 was fortunate in having, as its guest speaker, Dr. Donovan Ward, President of the AMA 1964-65. His announced title was Diagnosis and Treatment of Medicare, the end result of a certain disease which was brought into our country by the Fabians from England about the turn of the century. Thus it stems, as do we, from the Old World and today we share the products of their work as the disease has reached epidemic and pandemic proportions.

In recent years it was more or less fashionable for columnists to pan the AMA. One has said that anyone who warns of socialized medicine in the United States will be accused of being a tool of our parent organization. And there are hosts of politicians, among others, in Washington who pursue deep, ominous, and pervasive activities concerned with healing the sick, the aged, and the infirm.

Dr. Ward at once told his audience that he speaks not as an AMA past-president, but rather as an American citizen who believes in free enterprise and as a private practitioner of medicine. What's wrong with Medicare, he asked. For one thing, some nineteen million people became eligible last July for "free" medical care and untold millions are paying the bill—and will pay and pay, now and henceforth. The care goes to *all*, even those who don't need it and more who don't want it, just because they had a birthday—65. Thus, it is *not* based on need; it is *a tax, not insurance!*

After a mere eight months' trial run, all kinds of other " - - - cares"

are cropping up, not limited to any one segment of the population. When we oppose them, we are called negative. The proponents haven't been satisfied to let the Bill be launched, put in working order, to be interpreted and understood and to progress in an orderly manner. Already the machinery is being initiated to provide podiatry, eye glasses, generic drugs. Congress is being asked to delete the three dollar charges and the fifty-dollar deductible provision, to include *all* disabled people, to reduce the age to 62 or even 60, to include *all* widows. Why all this in the face of such limited experience? Distrust of physicians is shown by those who demand certification and recertification of medical necessity, and who question our interpretation of our usual, reasonable, and normal services and charges.

Apparently Social Security wants full control to limit intermediary carriers. How long will it be before the Department of Health, Education and Welfare will say they can do the job better without *any* intermediaries? Some of these carriers already wonder if they can carry on without local or regional custody of the records, about half of which have to be returned to patients for more information. The maze of paper work, misunderstanding, and bureaucratic management is what Congress is thinking of expanding! They don't admit that this is the greatest cause of rising medical costs. It is an established fact that *any* service taken from private and placed in government hands requires greater operating costs. Disregard of this truth is an insult to human intelligence. Our profession warned of this but were not paid heed, and now the public is bewildered regarding what Medicare will and will not do. We and our office employees are seeing more evidence of this every day. The older patients can't understand why Medicare doesn't pay all the bills. They don't know the first thing about it. Furthermore, the average wage

earner is already bewildered and his world is topsy-turvy. Why, many of them feel, should they argue with the promise of security and medical care in their later years? This is the question for us to answer.

Some of the reasons for them to argue are stated above—and the workers need to be told. *This project is our responsibility!* Can we be blamed if we continue to oppose a measure which depends upon public ignorance for its survival? We fought and we twitched a few times while the "you asked for it, we gave it" 89th Congress put it through. We must do a lot more than twitch before America loses all of its freedom down a road of no return leading to the welfare state. Unfortunately, a few doctors have relaxed and aver that everything is just dandy—like modern art, things can't possibly be as bad as they are painted!

Now is the time for all of us, and everybody else to take a second look. The press is doing so. Walter Lippmann says it stinks! We'll let that be his word, then hasten to admit that Medicare isn't all bad. It is still our job to see that America shall maintain its standard of the best medical care on earth, and we haven't the right to wash our hands of the whole affair. Where it is to our patients' advantage, let us go along with it. However, our generation, our children and their children must be educated to get it off the books, in its present form, while there is still time to get our country back on the right path before half or more of the population is included in the great give-away. This will happen unless our profession and other citizens of America work to preserve freedom. All can aim to make a bad situation better. Where the law is good, work with it; study its faults, point them out constructively to all levels of the population.

It is not the function of government to keep its citizens from erring, but rather for citizens to keep their government from falling into error!

Physicians still active, the trainees, medical students and all future physicians must continue to search for a better way, to question, to probe, seek and find a cure for the Disease. And even then, still be unsatisfied!—**Douglas W. Macomber, M.D., Editor, *Rocky Mountain Medical Journal*, 64:47, April, 1967. Reprinted with permission.**

The World Medical Association, Inc.

INDIVIDUAL membership in The World Medical Association is now open to all members of the American Medical Association.

Dues are \$10 per year. This includes a subscription to *World Medical Journal* and the privilege of participation in the World Medical Assembly each year.

The 21st World Medical Assembly will be held in Madrid, Spain, September 10-17, 1967. The 1968 Assembly will be held in Australia.

The World Medical Association is a society of the free, professional medical associations of the free nations. Sixty national medical associations are members, including the AMA.

The 20th World Medical Assembly last winter in Manila created for the first time an individual associate membership within the WMA. Members of the national medical associations may now join WMA as individuals.

Gerald D. Dorman, M.D., of New York City, member of the AMA's Board of Trustees, is Chairman of the Council, governing body of the WMA. The WMA Headquarters Secretariat is located at 10 Columbus Circle, New York City. Secretary General is Alberto Z. Romualdez, M.D.

Application for individual membership may be made to WMA at the New York City office. Applications should be accompanied by a check for \$10, with a statement that the applicant is a member in good standing of AMA. The letter should specify

whether the applicant wishes to receive the *World Medical Journal* in the English, Spanish or French language edition. Checks should be made payable to The World Medical Association, Inc., a tax-exempt organization. Five-year memberships are available for \$50. Information regarding the 21st World Medical Assembly will be mailed promptly to all applicants for individual membership.—**Suggested AMA editorial.**

Editorial Notes...

The Supreme Court of New Jersey has ruled that properly-conducted experiments on live animals by high school students does not violate the state's cruelty to animals law. The decision was made on an appeal of a finding by a lower court on a case in which the SPCA sued the Board of Education of East Orange for violation of the New Jersey Cruelty to Animals Act by sponsoring supervised biological experiments for entrance into the Science Fair exhibit. The experiment which was cited was one involving Rous chicken sarcoma. It won an "honorable mention" in the Newark Science Fair and first place in a later Science Fair in East Orange.

A paper read at the recent annual meeting of the Industrial Medical Association by Dr. Forrest E. Rieke of Portland, Oregon, reports his custom of repairing inguinal hernias under local anesthesia and allowing the patients to walk to their rooms from the surgery. He also reports less pain, less nausea and less headaches than observed with other methods. Patients leave the hospital two or three days earlier than those with general or spinal anesthesia and many of them return to work a few days after being discharged from the hospital.

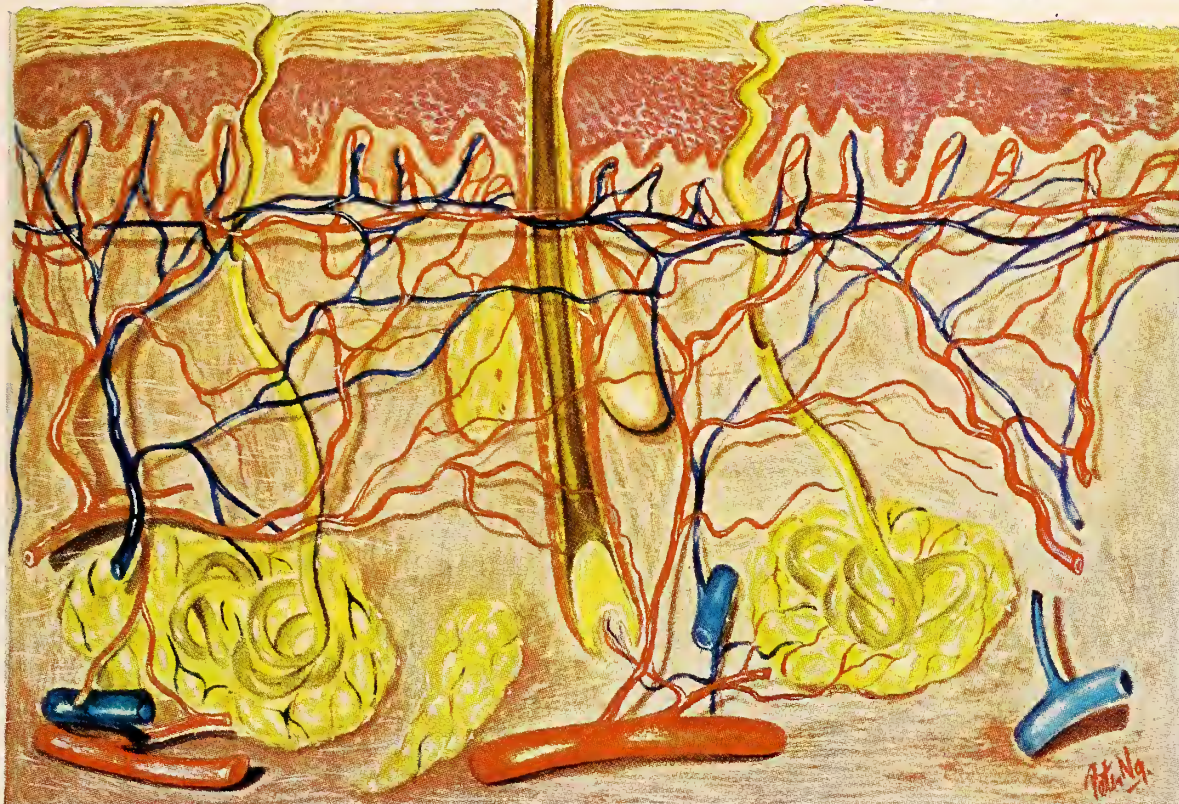
Dr. G. Morrison Carstairs, a psychiatrist of the University of

Edinburgh, comments on American medical schools in *Pharos*, magazine of Alpha Omega Alpha, and cites five schools—Yale, Stanford, UCLA, Duke and Indiana University—as the most forward-looking. He bases this opinion on the observation that these schools have altered curricula in the direction of "sacrificing completeness of coverage in favor of stimulating the student's comprehension of the scientific approach of each different aspect of medicine, and showing students how to find out things for themselves."

Solid waste disposal will be given a trial by the Public Health Service through a grant of \$178,200 to partially finance the transportation of solid wastes by railroads to abandoned strip mines and other types of desert land which might be reclaimed and rehabilitated. The use of unit trains, similar to those used for coal, is contemplated; compression and packaging of waste will be studied. Creation of useful land areas by methods similar to the sanitary landfill is the secondary object but finding a place to hide the trash is the big idea.

American expenditures for health care in 1965 were 9.5% above those for 1964. In spite of this increase, we spent more for liquor and tobacco (\$21.4 billion) than for hospital, drug and doctor bills (\$19.8 billion). Physicians in 1965 received exactly the same proportion of the health care dollar as they did in 1960 (27.7 cents). Hospitals in 1965 received an increasing amount (30 cents) as compared with 26.6 cents in 1960. The proportional cost for drugs decreased during the five years, from 18.9 cents to 16.4 cents. ◀

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B — bacitracin — neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ¼ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'[®]

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Why these 7 patients with **moderate to severe anxiety** may respond better to Mellaril

1. The agitated patient.

Anxiety—particularly that beyond the range of minor tranquilizers—frequently is expressed as gross motor restlessness, fidgetiness and purposeless movements, and may erupt into aggressive behavior. Mellaril is almost a specific for those patients whose anxiety follows such a pattern.





2. The psychosomatic patient.

The family physician is rarely given the diagnostic luxury of a classic, textbook "anxiety state." Most often he must probe for anxiety masked by a functional disorder—or which exacerbates a somatic problem. Double-blind evaluations have demonstrated that Mellaril can be a significant adjunct in the treatment of such patients.



3. The patient under situational stress.

Mellaril helps the patient deal with stresses of everyday life. Nonhabituating, it can be given for extended periods of time. It does not "separate" the patient from practical problems and pressures, does not induce euphoria or a fuzziness which can compromise the ability to cope with realities. Rather, it helps the patient move more competently in his daily world by eliminating useless tension, by allowing him to conserve emotional resources and energies, and to direct them against the problems really worth worrying about.



4. The menopausal patient.

The woman who sees change of life as the end of useful life requires support from both family and family physician. Whether the psychological impact of menopause is directly related to hormonal changes, or merely coincidental, is debatable, but estrogenic therapy is frequently inadequate. Mellaril is a useful aid for these patients and, alone, or in combination with reduced estrogen dosage, will help ease the menopausal misery.



5. The previously hospitalized psychiatric patient.

Such a patient may still require the type of medication he has been accustomed to, but because he is no longer in a controlled setting the acceptable level of adverse reactions must be lower. In such circumstances Mellaril is perhaps the drug of choice.



6. The agitated geriatric.

Tranquilizer therapy in the elderly patient always involves special (or at least accentuated) problems: the possibility of drug-induced ataxia, hypotension or depression, for example, assumes an additional significance. These reactions have rarely been observed in geriatric patients treated with Mellaril.



7. The constantly returning patient.

The anxiety patient who has not responded to a minor tranquilizer is not very likely to benefit from your minor tranquilizer of second choice. A major tranquilizer, such as Mellaril, may be indicated in such patients.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

in moderate to severe anxiety, 25 mg. t.i.d.

Mellaril[®]
(thioridazine)

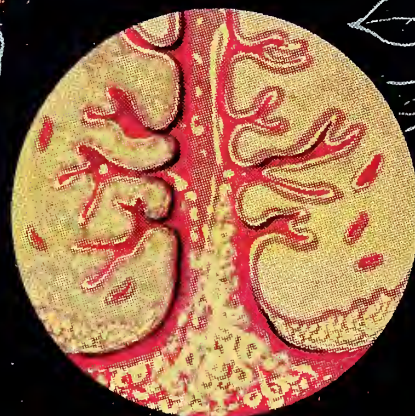




Periurethral glands



Bartholin's gland



Cervical glands

Flagyl[®].....

brand of

metronidazole



Seminal vesicles



Prostate gland



Bladder

Destroys Trichomonads Wherever They Are

Flagyl seeks out the sites where trichomonads hide. Only a systemic agent can. Flagyl does, selectively and effectively.

Flagyl destroys trichomonads in the inner crypts, glands and cavities of the genitourinary tract in both women and men. Consequently, Flagyl is capable not only of curing trichomoniasis in women but also of preventing reinfection.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced up to 100 per cent cure in large series of patients.

When the diagnosis of trichomoniasis is positive, Flagyl is positive.

Dosage and Administration—In women: one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men in whom trichomonads have been demonstrated: one 250-mg. oral tablet twice daily for ten days.

Contraindications—Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution—Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects—Infrequent and minor side effects include nausea, metallic taste, furry tongue and headache. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness of an extremity, joint pains, confusion, irritability, weakness, flushing, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

A surrealist illustration of a man's torso. A large, gnarled tree trunk grows from the center of his chest, with its branches spreading out like a pair of lungs. The branches are colored in shades of blue and white, contrasting with the man's skin. The background is a soft, hazy landscape with green foliage and a body of water. The overall style is painterly and evocative.

at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food^{1,3}

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.^{1,2} Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.^{1,3}

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels

attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:

New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

Ilosone®
Erythromycin Estolate



(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten-day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: *Am. J. M. Sc.*, 247:69, 1964.
2. Griffith, R. S., and Black, H. R.: *Antibiotics & Chemother.*, 12:398, 1962.
3. Hirsch, H. A., Pyles, C. V., and Finland, M.: *Am. J. M. Sc.*, 239:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Coming home is wonderful

when you have Blue Cross-Blue Shield

Here's a homecoming that was wonderful for everyone—thanks to Blue Cross-Blue Shield. From the instant recognition of the membership card at the hospital to the discharge later with virtually nothing to pay, this family appreciated their Blue Cross-Blue Shield service. Dad's boss had a good feeling about it, too—once again their group health care plan had paid off even beyond expectations. What's more, the boss didn't have to bother with claims-

filing and other administrative red tape.

Blue Cross-Blue Shield handles things directly with hospitals and with doctors—doesn't bother members or their bosses. That's one reason why employees *and* employers are so strong for it.

Actually, in these days of quality but higher cost medical care, you can't afford to be without the protection of Indiana's No. 1 health care plan. As they say around the happier homecomings—**"I don't know what we would have done without Blue Cross-Blue Shield."**

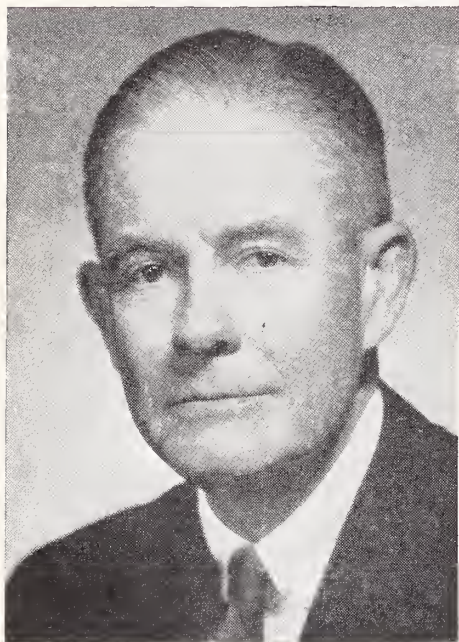
Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series
of ads being run
in key Hoosier
newspapers)

Meet The Journal Staff



DR. RAMSEY

Dr. Frank B. Ramsey has been Editor of *The Journal* since 1949. He was Associate Editor for one year in 1948.

Dr. Ramsey is engaged in the full-time practice of general surgery in Indianapolis. He attended Indiana University and received the A.B. degree in 1924 and the M.D. degree in 1927. His internship was at the Indianapolis City Hospital (now the Marion County General Hospital). Following this he was a surgical resident at the Long Hospital in Indianapolis for three years and then spent two years as a Fellow in Surgery at the Lahey Clinic, Boston.

He is Associate Professor of Surgery at Indiana University and is on the active surgical staffs of the Methodist, St. Vincent's and Winona Memorial Hospitals in Indianapolis. He also serves as a Civilian Consultant in Surgery to the Surgeon General of the Army.

He is a diplomate of the American Board of Surgery; a Fellow of the American College of Surgeons and the American Medical Writers Association and a member of the American Goiter Association.



MRS. STAHL

Jackie Stahl has been the Assistant Editor of *The Journal* since 1962. She is a graduate of Howe High School of Indianapolis and holds the B. S. degree from Butler University in Journalism and English.

Mrs. Stahl was active in student affairs in college. She was secretary and treasurer of the Butler Independent Student Association, secretary of the sophomore class and treasurer of the junior class. She was a member of Theta Sigma Phi, a journalism fraternity, Kappa Tau Alpha, a journalism honorary fraternity, the Psychology Club and the Press Club, and was further distinguished by being chosen as president of each of these organizations.

She was an active and hard working staff member of the Butler University newspaper, *The Butler Collegian*, and served terms as city editor, social editor and feature editor.

After graduation she was the Associate Editor of *The Shield*, a publication of the Indiana State Police, for one year. Mrs. Stahl then went to the city desk of *The Indianapolis News* for two years, where her major assignment was writing news stories telephoned in by reporters on various city, state and federal "beats." She also interviewed visiting celebrities and wrote feature articles. During this time she won an award for a series of articles on the United Fund agencies.

Mrs. Stahl was the Movie, Radio and Television Editor of *The Indianapolis News* from 1955 to 1957. During this time she appeared in a movie, "Teacher's Pet," with Clark Gable, Doris Day and Gig Young.

Her duties as Assistant Editor of *The Journal* include a variety of administrative and technical chores. Mrs. Stahl edits and proofreads all copy, schedules advertising, supervises the preparation of illustrations, plans the cover art, collects the news notes and personals, oversees the financial management, conducts the correspondence, arranges and collates each issue prior to printing, corrects and amends The Roster, is *The Journal* necrologist and compiles the yearly index.



MR. WAGGENER

James A. Waggener has served as Business Manager of *The Journal* and Executive Secretary of the state association since 1951. For two years prior to this time, he conducted the association's campaign against the Wagner-Murray-Dingle governmental medical care plan and established the field program of the association when he was appointed as the association's first field secretary.

Mr. Waggener's entire professional life has been spent in journalism and community medical services. He has participated in the organization and management of medical service care plans, community hospitals, government medical care plans, as well as his work with the Indiana State Medical Association and numerous voluntary organizations of medical society executive officers.

Early in his career he was successively Advertising Manager of *The New Castle Times*, *The Delphi Citizen* and *The Franklin Star*. He left *The Star* in 1947 to establish the Public Relations Department for Indiana Blue Cross-Blue Shield.

During World War II he was Civil Defense Director of Franklin, Indiana, and also published *The Camp Atterbury Crier*, a weekly newspaper with a circulation of 75,000. At the close of the war he was chairman of the committee which built the Johnson County Memorial Hospital, and also was secretary of the board of trustees of the hospital for four years.

Mr. Waggener served on the Advisory Committee to the Department of Defense for the implementation of the original Military Medicare Law.

He has served on the Public Relations Advisory Committee of the American Medical Association. He is a charter member of the Professional Section of the Public Relations Society of America. He has been Secretary-Treasurer of the Conference of Presidents and Other Officers of State Medical Associations since 1954, and is a member of the Board of Directors of the Professional Convention Management Association.

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 9-12, Indianapolis, Indiana.

I propose to exhibit _____

Name _____

Address _____

City _____

State _____

President's Page

Dear Doctor:

I have recently returned from the AMA Convention in Atlantic City. Your delegates upheld the instructions of the ISMA Council to help elect Dr. Edward Annis if at all possible. I feel that their contributions to his campaign were not small.



Dr. Annis was elected to the Board of Trustees of the AMA on the first ballot. The delegates also worked admirably on the floor to pass the resolution concerning the dispensing of drugs which was presented by the Indiana delegation. While we had no candidates for office in the American Medical Association in this particular meeting — the unity which was shown by the Indiana delegation will certainly make it easier for campaigning in the future.

It seemed to me that this AMA Convention showed a return to the conservative point of view of the entire AMA. The idea of compromising with government without regard to those freedoms that are lost seems to be gradually changing to the idea of talking with government, but giving up no rights.

I would urge the members to look forward to the October meeting of the Indiana State Medical Association. I would hope that each county might study resolutions that they feel are a necessity for our continued good welfare. I think especially that each county should look at the officers to be elected this fall and to make a choice of those candidates offered in order that we may have the best men available in office. Never before has medicine needed its finest members for spokesmen and for officers.

Eugene S. Rifkin M.D.

READING CARD

SNELLEN CHART

E — 200
N Z — 120
Y L S — 60
U F V P — 40
M T R X — 30
A G K — 20

SNELLEN RATING

Down, until over the market house
at made many a road on boat
I then went to the lake and
all in Boston. I asked for a three
they had none such. Not knowing

12

OPTICAL

he generous cheapskate I bade him
h of any sort. He gave me three
of the quantity but took it, and
I each arm. This I walked up
eth Street, passing by the house

13

e's father. She, standing at the
made a most awkward appear.
Then I turned and went down
of Walnut Street. Being filled
ve the other two in a woman

14

me the street had many clean
n it, all walking the same way.
I led into the great meeting
I sat down among them and
hile and hearing nothing said.

15

his was the first house
y, in Philadelphia. Look-
people. I met a young
nance I liked, and asked

17

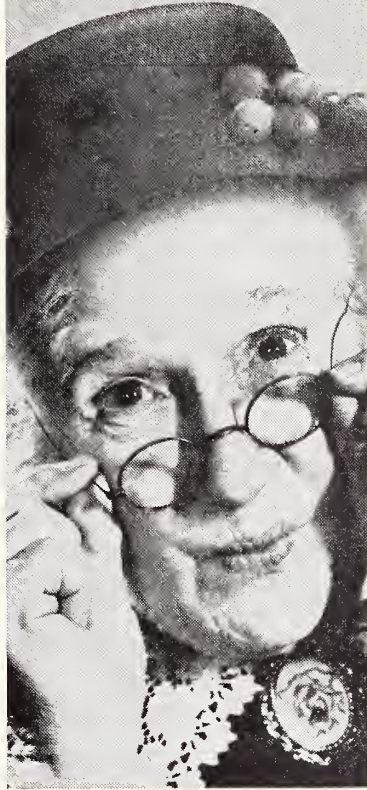
me where a stranger
ig. "Here," said he, "is
entertains strangers."

18

is at the designated distance in meters
notations at right.

THE WHITE-HAINES OPTICAL CO.

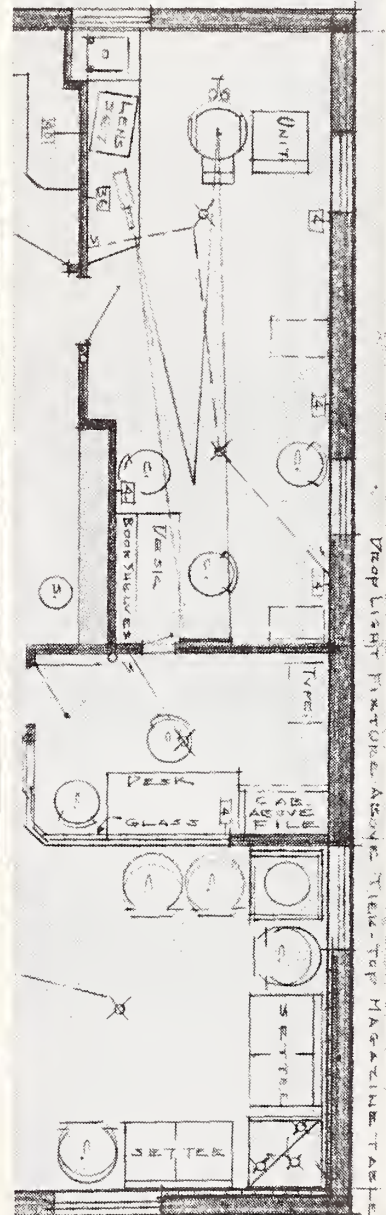
MRS. MURPHY



EVERYTHING

except
Mrs. Murphy

BLUE PRINT



comes from **WHITE-HAINES**

The reading card . . . the office-plan blue print.

Whatever you need . . . the simplest or most intricate optical equipment or professional service . . . White-Haines will supply it.

We call it "depth of service". We supply everything but the patient!

THE WHITE-HAINES OPTICAL COMPANY

Headquarters: Columbus, Ohio

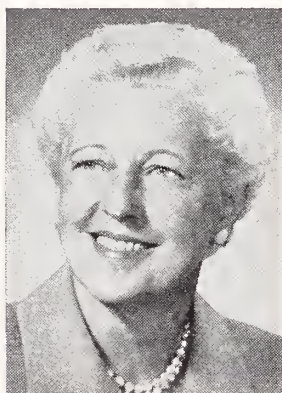
Serving Ohio • Michigan • Pennsylvania • West Virginia • Kentucky • Indiana • Illinois • Maryland

The Woman's Auxiliary

REPORTS TO ISMA

I recently had the opportunity to attend the Thirteenth Kirkpatrick Memorial Workshop on Aging. This workshop, held at Ball State University, was a most worthwhile meeting, full of first rate information from experts in their field.

The theme was "Reality Is as I See It—The Real World of the Older Person." The morning address "The Individual's and Society's Expectation Regarding the Older Person", was presented by Dr. Arthur Rosner, Director of Geriatrics at the John Madden Zone Center, Chicago. Dr. Rosner states that there is no definition for the "older person"—they differ through age, sex, education, involvement in the community and environment. Many persons are forced to retire at 65 and must learn to live on Social Security and pensions. It is at this time they must re-evaluate themselves. The retiree does not consider himself old—as society does.



There are vast differences between the ages of 65 and 80. Twenty-year-olds are more alike than 60-year-olds, 60-year-olds are more alike than those of 80. The psychological development in aging occurs from 40 years till death; these changes (shifts in personality) are not pathological but functional.

There are many crises that face the aged. Learning to live with less than the best of health, loss of status

through retirement, loss of significant people through death and finally, facing death themselves. For the elderly, time is not measured from birth but from death.

Dr. Rosner advocates bringing public health services into the home, rather than institutionalization. Day center programs, where the elderly can spend several hours each day, relieve the tensions of home situations. He also advocates day center care for the aged while families take well-earned, worry-free vacations, to restore physical and mental capacities.

At the second session, three viewpoints on the problems of aging were presented by labor, the professional and the homemaker. During the luncheon meeting, Dr. George Davis, Chairman of the Commission on Aging, advocated the formation of volunteer groups. It was interesting to me that these volunteers would perform the tasks that our national auxiliary is asking us to do, i.e., Volunteer Friendly Visitor, Homemaker Service and Meals-on-Wheels. The need for service is evident. I hope we can answer the call.

Roberta P. Deever



"North to Alaska"



April 23, 1967

Dear Dr. Ramsey,

Greetings from the Far North. After having lived and worked for the Upjohn Co. in Alaska these past 20 months, I feel I qualify as a quasi-authority on the "last frontier."

The practice of medicine in Alaska is no different than in Indianapolis. The same patient complaints are heard and the same drugs are used to cure the ill. The one difference that I have found is that there are many more physicians in group practice than in individual practice, especially in Anchorage and Fairbanks. The physicians are quite busy since there are only 121 civilian M.D.'s to serve a population of 255,000. URI's, alcoholism, tuberculosis, otitis media and gonorrhea top the list as the main complaints, especially among the natives (Indian and Eskimo).

In a recent publication, it was stated that during 1966 the following was consumed by the Alaskan populace: 1) whiskey—585,000 gallons, 2) beer—1,250,000 gallons and 3) wine—365,000 gallons. With a population of 255,000 (50% children), I assume that: 1) the tourists consume quite a bit or 2) we Alaskan's do. I have estimated that the average adult Alaskan weighs 193 lbs., which includes a 63 lb. liver.

My territory, of 586,240 square miles, is quite different from the ones I have had in the past. Since leaving Indianapolis in July, 1965, I have flown 75,000 miles, been above the Arctic Circle three times, have been "weathered in", snowed in, fogged in and "mechanical-failed in" several times. I have flown in every conceivable type of aircraft except a helicopter. I have also traveled by taxi, boat, snow mobile and dog sled.

The fringe benefits associated with this territory are innumerable. Fishing and hunting are just fantastic. I never thought I could get tired of taking fish off a hook until Alaska—I refuse to say more because the majority of Izaak Walton's would not believe it anyway. I was fortunate enough to go on a combination fishing and brown bear hunt at the Karluk River on Kodiak Island last fall. We saw nine Kodiak bears, but shot only one eight-footer. The fishing was just tremendous and this was in conjunction with work.

While I was detailing the only physician in Cordova last fall, I mentioned the fact that the Copper River Delta was world famous for duck and goose hunting. He replied that it was and if I would cut it short, we would go hunting. Well, I did and we did, but no luck. As you have

probably assumed, the detailing up here is a little more relaxed compared to the lower 48.

I would like to clear up a few misconceptions about Alaska before I continue. We live in Anchorage, a very metropolitan city of 110,000 persons. We do not live in an igloo, but a beautiful three bedroom home with two huge fireplaces. I do not have a company dog sled, but a 1967 air conditioned, four door hardtop Fury III. The weather in both Anchorage and Fairbanks is not as severe as many people believe. Anchorage averages 13°F in January (the coldest month). Fairbanks is a bit colder. I have worked there at -45°F, but with low humidity and no wind, it is not as cold as standing on Meridian and Washington St. in mid-December.

My wife, Sue, and sons, Scott and Greg, have acclimated rapidly to the Alaskan way of life. We have panned for gold successfully, picked blueberries and cranberries by the bucketful, camped, hunted, fished, ice skated and even taken up skiing. We have not, as yet, sustained any fractures and the season is nearing a close.

I have the distinction of having the largest territory, geographically, with the Upjohn Company. I travel

from Kotzebue, above the Arctic Circle, south to Nome, Fairbanks, Glenallen, Valdez, Palmer, Kenai, Soldotna, Seward, Cordova, Kodiak, Juneau, Sitka, Petersburg, Wrangell and Ketchikan and still find time to fly out to either Seattle or Portland every eight weeks. I am gone from Anchorage about 50% of the time.

The remaining time in Anchorage is spent calling on 75 civilian physicians and 80 government physicians (military and USPHS).

If you know of any physician who likes to fish, hunt and work hard, there is a golden opportunity for him in Alaska. This is a young and dynamic state and it will grow rapidly in the next few years.

I must close now. Please give my regards to all in the Indianapolis area and if you know of anyone desiring any additional information, have him contact me.

Sincerely yours,
Ron Brown
907 Southampton Dr.
Anchorage, Alaska 99503

Medical Students Urged to Stay in Indiana

APPROXIMATELY 200 junior and senior medical students, their wives and guests attended the annual Junior-Senior Day program sponsored by the Indiana State Medical Association, Saturday, April 1.

Dr. Eugene S. Rifner, Van Buren, president of ISMA, welcomed the group to the Holiday Inn-Airport, Indianapolis. The affair is held annually to encourage medical graduates to establish their practices in rural Indiana.

"The program, conducted for the past 13 years, follows the current concern by ISMA officials, the Indiana University School of Medicine and the state legislature to retain Indiana graduates," Dr. Rifner said.

The program included a discussion by Dr. Barton C. Bridge of Lafayette on the pros and cons of partnership practice.

Also included was a panel discussion on the ISMA's preceptor program which is in its third year of successful operation. Panel members included Dr. Bridge, Dr. and Mrs. Francis H. Gootee, Jasper, and Dr. Richard J. McAlpine, Indianapolis. Introductory remarks for the panel

presentation were made by John Dugan, Indiana University medical student, who had participated in the preceptor program.

Speaker for the banquet was Mr. James C. Bostain, scientific linguist, United States Department of State. Other participants included Dr. Glen V. Ryan, Indianapolis, president of

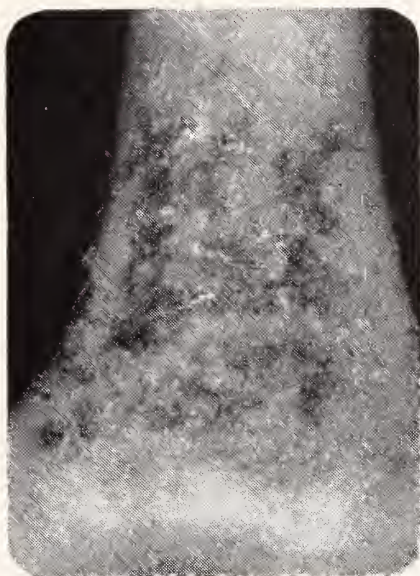
Indiana Blue Shield and Mr. Herbert Ashby, company historian of Mead Johnson Laboratories, Evansville.

Members of ISMA who planned the event were Dr. Thomas O. Middleton, Bloomington, chairman of the Commission on Public Health, and Dr. T. Neal Petry, Delphi, program chairman.

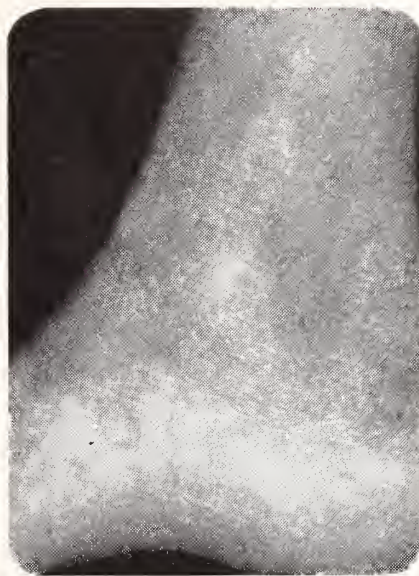


MEDICAL students, their wives and friends chat at coffee-break during the ISMA annual Junior-Senior Day program.

Eczema of many years... controlled in two weeks



Before treatment



After treatment —
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side

effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort®

Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-G

JACK W. HICKMAN, M.D.
Indianapolis

Mitral Replacement or Mitral Fracture?

A fine succinct article by Belcher¹ examines the very important question of "What are the indications for mitral valve replacement?" The records of 402 patients who had surgery, mostly finger-fracture, from 1952 to 1960, were studied. Because of the greater risks inherent in valve replacement procedures and the, as yet, uncertain long-term results of the prosthesis, the author feels that mitral valve replacement should not be done unless there are strong indications present. He feels that severe preoperative mitral insufficiency is such an indication. Such things as mild to minimal preoperative insufficiency, and postoperative insufficiency may at times be strong enough indications. He feels, however, that restenosis and even extensive valvular calcification by itself are not indications for valve replacement. This is indeed a more conservative approach than has been advocated by others, but it is a well-presented one and deserves serious attention.

Mild Anemia and Chronic Alcoholism

The mild anemia that is often seen in patients suffering from Laennec's cirrhosis is usually ascribed by the clinician to "oozing" from esophageal varices, low prothrombin tests, gastritis or some combination of these, even if none can be demonstrated objectively. Other factors that

have been cited are decreased erythropoiesis, iron and folic acid deficiencies and increased hemolysis. Waters, Morley and Rankin² report a present study to support previous evidence that ethanol itself plays an important role in the anemia by its direct depressive effect on erythropoiesis. This conclusion was arrived at by hematologic studies on 16 patients who were chronic alcoholics but were not cirrhotics. The toxic effect of the ethanol was demonstrated by derangement of ferrokinetics and rather striking cytoplasmic vacuolation of red cell precursors in the bone marrow. Significant numbers of the subjects also showed iron and/or folic acid deficiency.

Senile Epilepsy is Possible —and Treatable

Epilepsy is not seen frequently in the aged, but Fine³ draws attention to the fact that this quite disturbing, if not necessarily debilitating, condition can develop after cerebral thrombosis. The author feels that the condition is much more frequent than is generally recognized. He stresses the fact that the condition responds to the usual anticonvulsant therapy. The diagnosis is usually not considered, since the clinician feels that the episodes are repeated cerebral vascular accidents and does not therefore institute anticonvulsive medication. Sensory manifestations as well as motor can occur, and these are usually confused with thalamic

pain or senile dementia. Most of us are not ready to agree with the author's suggestion that all patients who have suffered from a cerebral thrombosis might be placed on anticonvulsants, but we should certainly be more aware of this condition.

Thymectomy Fails in Lupus and Rheumatoid Arthritis

The thymus has certainly been the gland of this decade. As more and more conditions have been alleged to be autoimmune in nature, it follows that sooner or later surgeons would be removing it in patients who have the diseases under study. Eight authors writing a paper about their results with five patients usually means trouble. The paper by Milne et al.⁴ describes their results with thymectomy in three patients with systemic lupus erythematosus and two patients with rheumatoid arthritis. The five patients did not improve nor become worse as a result of the thymectomy. Back to the drawing board!

BIBLIOGRAPHY

1. Belcher, J. R.: What are the Indications for Mitral Valve Replacement? *Brit. Med. J.* 2:1486-1489, No. 5528.
2. Waters, A. H., Morley, A. A., Rankin, J. G.: Effect of Alcohol on Haemopoiesis, *Brit. Med. J.* 2:1565-1568, No. 5529.
3. Fine, Wilfred: Post-hemiplegic Epilepsy in the Elderly, *Brit. Med. J.* 1:199-201, No. 5534.
4. Milne, J. A., Anderson, J. R., MacSween, R. N., Fraser, K., Short, I., Stevens, J., Shaw, G. B., Tankel, H. I.: Thymectomy in Acute Systemic Lupus Erythematosus and Rheumatoid Arthritis, *Brit. Med. J.* 1:461-464, No. 5538. ◀

New drugs take exams, too.

Today, virtually every medical school in the United States cooperates with pharmaceutical manufacturers in the clinical evaluation of new and promising drugs. Just as you might find it significantly more difficult to practice medicine without the useful new compounds made available through original pharmaceutical research in the past twenty years—prescription-drug manufacturers would find it equally difficult to obtain extensive, long-term, dependable evaluations of new therapeutic agents without the close cooperation of medical staffs and clinical

facilities of medical schools and teaching hospitals. Such cooperation leads toward more effective care of more patients—the common goal of medical and pharmaceutical research—toward reduction in the cost of disease, toward increase in useful longevity.

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.



**Pharmaceutical
Manufacturers Association
Pharmaceutical
Advertising Council**

1155 Fifteenth St., N. W., Washington, D.C. 20005



In managing tense, anxious patients
here's one combination that makes sense:
your understanding counsel
and **Serax[®]**
(oxazepam) Wyeth

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly (see Wyeth literature or PDR as well as "IN BRIEF" below).

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures. Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

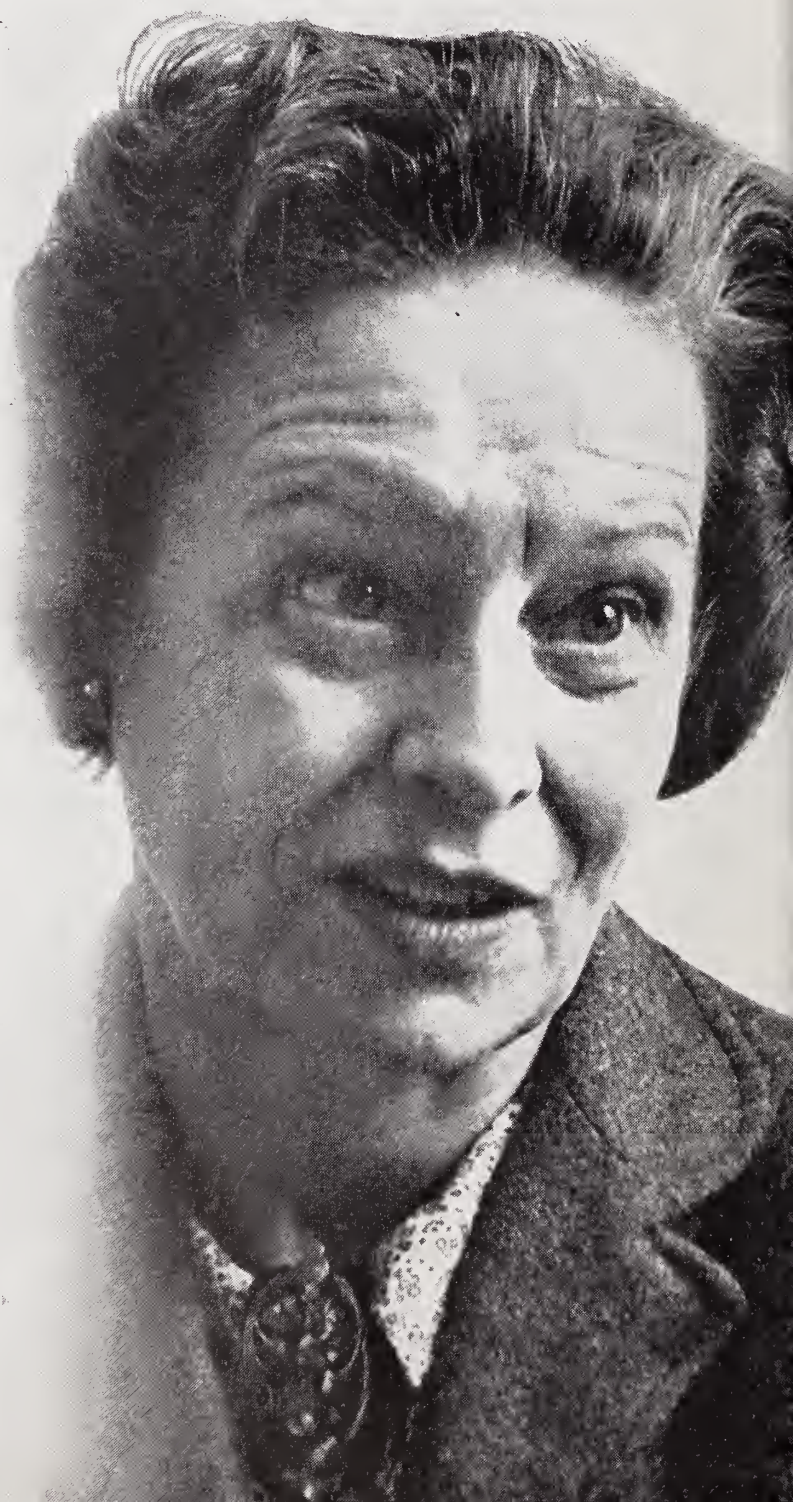
Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds, not established.

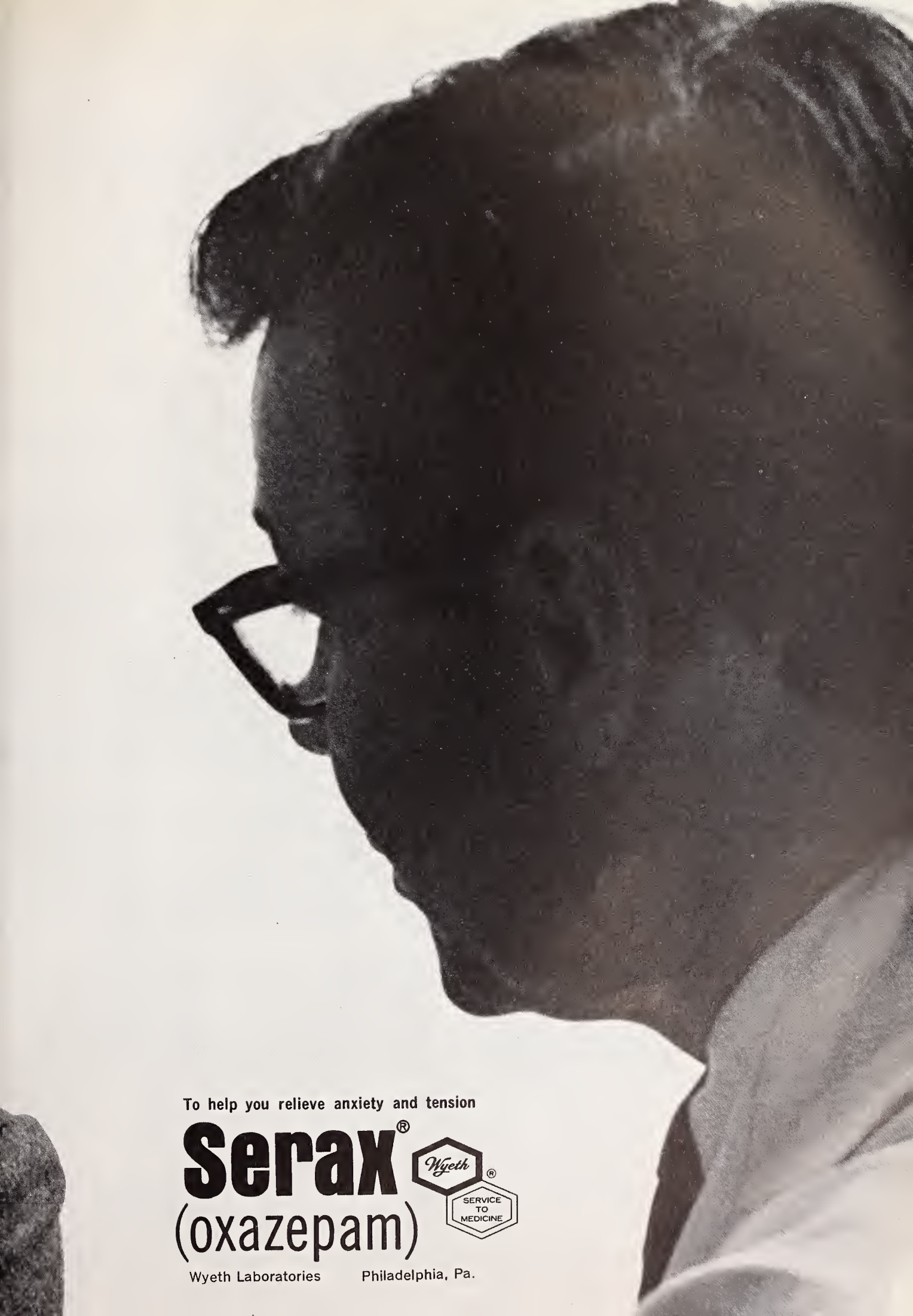
Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age.

These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

Photograph posed by professional models.





To help you relieve anxiety and tension

Serax[®]
(oxazepam)



Wyeth Laboratories

Philadelphia, Pa.

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Job Stress as Cause of Progressive Arteriosclerosis Not Established by Medical Evidence—

A train dispatcher was not entitled to recover damages in a suit against his employer, under the Federal Employers' Liability Act, for the alleged negligence of the employer's physician in returning him to his job, the emotional strain of which aggravated his arteriosclerosis to the point of disability, a California intermediate appellate court ruled. The judgment based on the jury's verdict in favor of the dispatcher was reversed, with directions to enter a judgment notwithstanding the verdict in favor of the employer.

In 1959, a physician of the employer diagnosed the dispatcher's condition as general arteriosclerosis. After a bilateral sympathectomy and several weeks of treatment, the physician permitted the dispatcher to return to his job. About two years later, the dispatcher returned to the physician with complaints of severe chest pains after exercise. The physician found that the dispatcher's arteriosclerotic condition had worsened. He refused to allow the dispatcher to return to his job because he thought that the emotional stress operating on the dispatcher's physical condition might cause a heart attack. The dispatcher has never had a heart attack. The dispatcher contended that the employer's physician was negligent in permitting him to return to his job in 1959, and that the stress of the

job had aggravated his arteriosclerosis to such an extent that he is now disabled.

By returning a verdict for the dispatcher, the jury impliedly found that the stress of his job was a contributing cause to the worsening of his arteriosclerotic condition. Since the etiology of arteriosclerosis is obscure and certainly not within the knowledge of laymen, such a finding must be supported by expert medical testimony. The dispatcher's medical expert did not state that the emotional stress of the dispatcher's job might have contributed to the aggravation of his arteriosclerotic condition. His testimony dealt only with the stress of the job as a contributory cause of a possible heart attack.

Waller v. Southern Pacific Company, 54 Cal. Rptr. 421 (Cal., Nov. 1, 1966).

Results of Blood Grouping Tests Overcome Presumption of Legitimacy—A husband was not liable for the support of a child born in wedlock to his wife, where the results of blood grouping tests conclusively excluded him as the father of the child, a New York trial court ruled.

A child born in wedlock is presumed to be legitimate, and more than a fair preponderance of evidence is necessary to overcome the presumption. A court must be completely satisfied that the alleged father is not the child's parent. A recognized expert in the field had made

six tests of the blood of the husband, the wife and the child. He testified that the results of those tests conclusively excluded the husband as the child's father. He also performed the test, in a simplified manner, in the courtroom, with the same result. There was testimony that the results of blood grouping tests, performed by properly qualified experts, are completely objective and unbiased, and are virtually infallible. This evidence was sufficient to overcome the presumption of the child's legitimacy. Therefore, the husband was not liable for the support of the child.

Crouse v. Crouse, 273 N.Y.S.2d 595 (N.Y., Sept. 15, 1966).

Blood Transfusion Ordered for Infant Over Parents' Religious Objections—A blood transfusion was ordered for an infant, whose parents refused, because of their religious beliefs as Jehovah's Witnesses, to consent thereto, by an Illinois trial court. There was medical evidence that the infant was suffering from hyperbilirubinemia and that an exchange transfusion was necessary to save his life. The infant was pronounced out of danger several days after the transfusion was given. (News Release, Chicago, Ill., Feb. 4, 1967).

Physician-Patient Privilege Not Waived by Bringing Personal Injury Suit—In a suit by a woman to recover damages for personal injuries, a trial court erred in order-

ing a physician who treated the injuries to furnish his records to the person against whom the suit was brought and to submit to an examination thereon, the Washington Supreme Court ruled.

During the taking of her pretrial deposition, the woman disclosed the name of the physician who had treated her. When the person against whom the suit was brought sought to obtain the physician's records and to take his pretrial deposition, the woman objected on the ground that such inquiry was barred by the physician-patient privileged communications statute. The trial court ruled that the woman had waived the privilege by bringing the suit.

The privilege statute provides that a physician cannot be examined in a civil action as to anything learned in treating a patient, without the patient's consent. Several states have enacted statutes providing that the bringing of a suit for personal injuries constitutes a waiver of the privilege as to those injuries. No such statute has been enacted in Washington. Whether the statute should be amended to provide that the privilege is waived by the bringing of a suit for personal injuries was a matter within the sole discretion of the legislature, the court said.

The woman did not waive the privilege by testifying, in her pretrial deposition, as to the nature and extent of her injuries. When the woman appeared in response to the pretrial subpoena, she appeared as an adverse witness. The privilege is not waived by an appearance as an adverse witness.

Bond v. Independent Order of Foresters, 421 P.2d 351 (Wash., Dec. 8, 1966).

Death From Asphyxiation Following Tonsillectomy Not Death by Accidental Means—In a suit against an insurer, double indemnity benefits for death by accidental means were not recoverable, where the insured died from asphyxiation

following a tonsillectomy, a New York trial court ruled.

After the apparently successful completion of the operation, the insured was brought back to the operating room, where he died a short time later of asphyxia by aspiration of blood. The policy provided that double indemnity benefits were not payable if death was caused or contributed to by disease or bodily or mental infirmity or medical or surgical treatment therefor. There was nothing in the record that anything other than the tonsillectomy, a surgical procedure, contributed to or caused the insured's bleeding and death.

Bracey v. Metropolitan Life Insurance Co., 275 N.Y.S. 2d 81 (N.Y., Dec. 2, 1966).

Hospitalization Insurer Not Liable for Insured's Drug Expenses Following Release from Hospital—In a suit against a hospitalization insurer, an insured was not entitled to recover the cost of drugs prescribed by her physician as treatment for her condition after her release from a hospital where she had undergone surgery for cancer, the South Carolina Supreme Court ruled.

The policy provided for the payment of drug expenses while the insured was hospital-confined or was an outpatient. "Outpatient" is not synonymous with "not hospital-confined." "Outpatient" means a patient who is not an inmate of a hospital, but who receives medical care from a service of a hospital. Every patient whose condition requires further treatment after his release from the hospital is not necessarily an outpatient of the hospital. In order for one to be an outpatient of the hospital, the treatment received must be hospital connected. There was no evidence of any connection between the drugs and any treatment at the hospital.

Harper v. Bankers Life & Casualty

Company, 151 S.E. 2d 98 (S.C., Nov. 2, 1966).

Fraudulent Concealment of Cause of Action Sufficiently Alleged in Patient's Suit—A physician's motion to dismiss a suit against him by a patient for injuries caused by his allegedly negligent treatment, on the ground that it was barred by the Colorado two-year malpractice statute of limitations, was denied by a federal trial court in Colorado.

It was alleged that the negligent treatment occurred in 1960 and that the patient did not discover the cause of her injuries until May 21, 1964. This suit was filed on May 18, 1966. The patient further alleged that the physician had fraudulently concealed the cause of her injuries.

The physician contended that the cause of action had to have accrued before April 10, 1960, because, since he did not treat her after that date, there could have been no "active concealment" after that date. Under Colorado law, the statute begins to run when the patient discovers, or reasonably could have discovered, the negligent act, rather than from the date of the last "active concealment." The patient's allegations of fraudulent concealment were sufficient. A showing of all the elements of fraud is not required to support a finding of fraudulent concealment. Whether the patient knew, or reasonably should have known, of the negligent act before the date she allegedly discovered it, was a question for the jury.

Murphy v. Dyer, 260 F. Supp. 822 (D.C., Colo., Sept. 2, 1966).

Pharmacist's License Suspended for Unauthorized Refilling of Prescriptions—The State Board of Pharmacy acted properly in suspending a pharmacist's license for 15 days and his drugstore license for five days for having refilled pre-

scriptions for dangerous drugs without the authorization of the prescribing physician, a California intermediate appellate court ruled.

Investigators for the Board obtained prescriptions, in the name of fictitious persons, for dexedrine, sec-onal and dexamyl from two physicians. Care was taken to insure that no refills would be authorized by the physicians, or their nurses or associates. The evidence established that the pharmacist did refill the prescriptions, even though he knew refills were not authorized. He refilled one of the prescriptions after having called the physician's office and being told that it should not be refilled. The Board was not required to present expert testimony that the drugs dispensed by the pharmacist when he refilled the prescriptions were the dangerous drugs called for by the prescriptions. The pharmacist himself testified that the drugs he dispensed were those called for by the prescriptions.

O'Mara v. California State Board of Pharmacy, 54 Cal. Rptr. 862 (Cal., Oct. 20, 1966; as modified, Nov. 3, 1966).

New Trial Ordered in Suit for Child's Death from Aspirin Poisoning—A new trial was required in a suit for damages against the government, under the Federal Tort Claims Act, for the death of a 15-month-old child, allegedly caused by the negligent failure of an Army physician to diagnose her condition correctly, the U.S. Court of Appeals for the Fifth Circuit ruled. The new trial was required because expert medical testimony on the issue of malpractice which was favorable to the government had been based on assumptions that were not supported by facts in evidence.

The child was brought to the hospital by her father at 9:45 p.m. because she had started vomiting and having diarrhea. On the basis of his examination and the fact that he had seen the child's mother earlier in the evening and found her to

be suffering from a viral infection of the respiratory tract, the physician made a similar diagnosis as to the child's condition and prescribed appropriate medication. The physician noted on the child's record that she was hyperventilated.

The child was brought back to the hospital the next day. She was "glassy-eyed" and unresponsive, and at noon she was semicomatose, 10-15% dehydrated, and breathing very rapidly. Under questioning by a pediatrician who had been called in for consultation, the father recalled that the child had been playing the previous afternoon with a bottle containing 300 adult aspirin tablets. Intensive treatment for aspirin poisoning was immediately instituted, but the child died that evening.

The evidence as to whether the child's life could have been saved if she had been treated when she was brought to the hospital the first time was such as to have permitted a finding either way. However, the trial court apparently based its finding, that the physician's failure to diagnose the child's condition was the cause of her death, on the failure of any witness to testify that, if the correct diagnosis had been made when the child was first seen, there was a reasonable medical certainty that her life could have been saved. No such specific testimony was required to establish proximate cause.

The trial court also found that there was no negligence on the physician's part in diagnosing the child's condition. There was expert testimony that his examination and treatment were in accordance with the standard for the area. The expert testimony was based on certain assumptions. One assumption was that the physician was told nothing of the possibility that the child had taken aspirin when she was seen for the first time. Although there was a conflict in the evidence on the point,

there was evidence supporting a finding that the child's father said nothing to the physician about the possibility.

Of critical importance on the issue of the physician's negligence was the child's hyperventilation. A pediatrician testified that when a child who cannot speak is hyperventilated, it is absolutely essential to determine the cause of the hyperventilation, because of the strong possibility that aspirin poisoning is the cause. He stated the opinion that the physician was, in view of the child's hyperventilation, negligent in not making further tests to determine its cause. In response to the government's questions, he stated that further tests were not necessary if the physician found conditions present which satisfactorily explained the hyperventilation. In its hypothetical questions to the pediatrician and to the other medical experts, the government assumed that: (1) the child sat quietly in her father's lap when she was first brought to the hospital and her breathing became different and she first became hyperventilated when the physician began the actual physical examination; (2) the child was crying so vigorously that it was impossible to determine the real cause of the hyperventilation. There was no evidence in the record supporting either assumption. Since the opinions that the physician was not negligent were based on assumptions for which there was no supporting evidence, the opinions were of no value, the court said.

The trial court's finding of fact as to what the child's father told the physician about a blueness about her lips was not completely accurate. In view of the importance of cyanosis as an indicator of aspirin poisoning, the inaccuracy could not be regarded as insignificant.

Rewis v. U.S., 369 F.2d 595 (C.A. Dec. 5, 1966).

New Trial Ordered in Suit Against Surgeon for Patient's Death Following Appendectomy—

In a suit against a physician and a surgeon for a patient's death following an appendectomy, a trial court erred in directing a verdict in favor of the surgeon. There was sufficient evidence to sustain a jury finding that there had been negligence on the part of the surgeon, the Court of Appeals of Kentucky ruled.

The physician diagnosed the patient's condition as appendicitis and had him admitted to the hospital. The next day, the surgeon was called in and performed an appendectomy. There was no negligence in the performance of the operation. However, the appendix was found to be in the upper left part of the patient's stomach, rather than in the right lower portion of his abdomen. There was evidence that, after the operation, the patient suffered extreme pain, that his stomach was appreciably swollen, and that his condition progressively deteriorated. Despite all of these things, the patient was discharged from the hospital a week after the operation. His condition worsened, and he was returned to the hospital. A second surgeon operated and found that the patient's intestines had somehow become twisted and that gangrene had set in. The patient died three days later.

It was alleged that the physician and the surgeon were negligent in having failed to ascertain and treat his deteriorating condition, and in discharging him from the hospital when he was seriously ill.

The trial court had also directed a verdict in favor of the physician. This was proper, because there was no evidence of any negligence on his part.

A medical expert testified that the location of the appendix should have aroused suspicion that the intestines might be involved, and that x-rays should have been taken in view of the patient's deteriorating condition. He stated that the patient should not have been discharged from the hospital. The witness stated that the patient's life

could have been saved if proper care and skill had been used. A jury could have found from this evidence that the surgeon was negligent.

The medical expert was qualified to testify, even though he could not and did not testify with respect to the standards of medical care that existed in the hospital where the patient was treated, the court said. His opinions were based on what he considered to be the standards of medical care in the community where the treatment was given. The procedures that he considered proper appeared to be generally accepted ones.

Lyon v. Wood, 407 S.W.2d 693 (Ky., June 10, 1966; as modified on denial of rehearing, Nov. 4, 1966).

Damages of \$1,200,000 Awarded in Suit Against MER/29 Manufacturer—

In a suit against the manufacturer of MER/29 by a patient who developed cataracts in both eyes, baldness, and scaling skin after taking the drug, the patient was awarded damages of \$1,200,000 by a New York trial court jury. The jury awarded \$350,000 as compensation for the patient's injuries, and \$850,000 as punitive damages. The patient asserted as the basis for an award of punitive damages that the manufacturer had been negligent in not testing the drug adequately and in not promptly and fully notifying the Federal Food and Drug Administration as to the drug's toxic effects. An attorney for the manufacturer stated that an appeal is planned. (News Release, Nov. 9, 1966).

Breathalyzer Test Results Admissible Although Device Not Specifically Approved by AMA—

In a prosecution against a driver for driving while under the influence of intoxicating liquor, a trial court did not err in admitting the results of a Breathalyzer test, even though the device had not received the specific approval of the American Medical Association, the North Dakota Supreme Court ruled.

The statute in effect at the time of the driver's arrest provided: "The re-

sults of a test given by means of the Harger Drunkometer or other similar device approved by the American Medical Association . . . shall be admitted in evidence when it is shown that the test was fairly administered." There was evidence that the AMA had not specifically approved the Breathalyzer. This absence of a specific approval of the device was due solely to the AMA's policy of not endorsing or approving any specific device or product and not because of any doubts on the part of the AMA as to the device's reliability. The statute did not condition the admissibility of test results on the AMA's approval of the device on which the test was made. The legislature referred to AMA approval only as one means of expressing its intention that the test given a driver was to be a reliable one. The evidence established that the Breathalyzer was reliable and that it had been fairly administered to the driver.

State of North Dakota v. Miller, 146 N.W.2d 159 (N.D., Nov. 10, 1966).

Chronic Alcoholism Not Defense to Drunken Driving—

The conviction of an accused on two charges of driving while under the influence of intoxicating liquors did not violate the Eighth Amendment's prohibition against cruel and unreasonable punishment, even though evidence was presented that the accused was a chronic alcoholic, a Georgia intermediate appellate court ruled. Temporary insanity, induced by drunkenness, is not a defense, but a person who suffers from permanent insanity, even though caused by drunkenness, cannot be held criminally responsible. No showing was made that the accused was under any permanent disability, or that he did not know right from wrong when he was not under the influence of intoxicating liquors.

Cook v. State of Georgia, 151 S.E.2d 155 (Ga., Sept. 20, 1966). ◀

Blue Cross-Blue Shield News

(One of a series)

Blue Shield Organization Changes

Announcement has been made of the following changes in the Indiana Blue Shield organization made at a meeting of the board of directors held in Indianapolis April 23.

Glen V. Ryan, M.D., who had been serving as president, was named chairman of the board and Mahlon M. Miller, M.D., who had been serving as vice president, was named vice chairman. Lowell Thomas, M.D. was re-elected secretary, and H. Prentice Browning was re-elected treasurer.

Richard C. Kilborn, who has been serving as executive vice president, was named president. V. M. Brian was named vice president, operations; Jules Hagen, vice president, finance; and Harry Hineman, vice president, actuary. H. T. Goodman, M.D. and Mahlon Miller, M.D. were re-elected to the executive committee.

Blue Plans Outpay Commercials

Blue Cross, Blue Shield and similar hospital-medical plans paid out approximately \$400 million more in hospital-medical member benefits in 1965 than did the insurance companies offering health insurance, according to the 1966 source book of health insurance data.

The 75 Blue Cross Plans, 75 Blue Shield Plans and other organizations covering only hospital-medical expense paid \$4.5 billion for their hospital-medical subscribers, reports the source book.

A breakdown of these amounts

shows that the Blue Plans and related groups paid \$3.1 billion in hospital benefits and \$1.4 billion in surgical-medical benefits, while the insurance companies remitted \$2.6 billion in hospital payments and \$1.5 billion in surgical-medical payments.

Although the insurance companies paid out less in benefits than did the Blue Plans, they collected more in hospital-medical premiums. The subscription income of the Blue Cross and Blue Shield organizations reached \$4.8 billion in 1965, whereas the insurance companies had a hospital-medical premium income of \$6.3 billion.

The \$4.8 billion Blue Cross and Blue Shield subscription income represented a 70% increase over 1960. The insurance company income, on the other hand, was only 57% higher than in 1960.

Gains in Federal Employees Program

Joseph E. Harvey, Director of the Blue Cross and Blue Shield Federal Employee Program, reports a net gain during 1966 of 409,641 FEP participants by Blue Cross and Blue Shield. He said enrollment in the program was 3,919,198 persons on January 1, 1966, and on January 1, 1967 was 4,328,839. The net gain includes 100,000 participants added during the November 1966 open season.

In his report, Harvey said the growth rate for 1966 was 10.4%, "Which is only slightly in excess of the increase in federal employment."

During 1965 the growth rate was 2.8%, he said. "The difference in the two years is undoubtedly the result of the armed services employing civilians to free military personnel that were performing clerical and other non-military duties," Harvey stated. "This trend appears to be continuing in 1967."

Blue Cross and Blue Shield now have enrolled 57.1% of all federal employees participating in the national program, up from 56.1% a year ago. "Aetna, the indemnity plan, now has 21.8% while employee unions and the comprehensive plans have 14.9% and 6.2% of the enrollment, respectively," Harvey said. He pointed out that Aetna's percentage dropped from 22.5% a year ago while employee unions dropped from 15.6% and comprehensive plans gained from 5.9%.

18 Federal Employees Have Received \$30,000 Benefits

Eighteen participants in the Blue Cross and Blue Shield Federal Employee Program have received maximum high-option supplemental benefits of \$30,000 since the program began in 1960. Mr. Harvey, director of the program, said that a survey of plans—with only two non-respondents—shows that five who received the maximum benefit live in the Washington, D.C. Plan area with three each from Philadelphia, New York City and California. Two live in Illinois and one each in Maryland and Texas. Harvey said that "anyone who reached the \$30,000 maximum is now eligible for an additional \$20,000—under the new high-option maximum—for expenses incurred on or after January 1, 1967." ◀

W. C. Huddleston
Communications Division

The Cancer You View

DISCUSSION

The lesion is obviously a neoplasm arising from the rectal mucosa. The margin, though elevated, is not rolled or undermined. The mass appears to be polypoid but with a broad or sessile base. The sigmoidoscopic examination showed the lesion to extend almost circumferentially around the bowel and to be 6 cm. in maximum width.

Multiple biopsies, obtained through the sigmoidoscope, revealed a villous adenoma. This diagnosis, though of a benign neoplasm, carries with it a threat of focal malignant change which is found in more than 40% of such lesions.

Although additional biopsies may be taken through the sigmoidoscope, it is obvious that the entire lesion requires surgical removal. This should be performed with whatever extent of surgery is technically needed. At times the lesion is so situated that an anterior resection and re-anastomosis of the rectosigmoid will suffice. If the lesion is much lower in the rectum, certain special technics may be used for its complete local removal. Even if abdominoperineal resection is needed for the complete removal of the lesion, it should be performed.

Complete pathologic examination

of the specimen, including blocks from many areas, is required. Often areas of atypical adenomatous pattern, of adenocarcinoma-in-situ, or of various stages of invasive adenocarcinoma will be encountered. If invasive carcinoma is not present, the prognosis is excellent. If invasive carcinoma is found, the biologic behavior of the lesion will be similar to any other adenocarcinoma of the rectosigmoid of equal grade and extent.

Large villous adenomata such as this often secrete large quantities of water, mucus and electrolytes so that in the older patient there may be a physiologic challenge to health from these losses. Any water or electrolyte imbalance, of course, should be corrected prior to surgical exploration.

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

W. R. VanDenBosch, M.D.

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

David L. Evans, M.D.

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

(Phone)

447-6404

743-1809

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

ABSTRACTS

BOOK REVIEWS

YOUR HEART HAS 9 LIVES

Alton Blakeslee and Jeremiah Stamler, M.D., Pocket Books, Inc., New York, 1966; 278 pages; \$0.75.

This is a pocket book size of this volume which was first published in 1963. Consequently it has value as a "loaner" or a gift from the physician who wants to so inform his patient.

For those unfamiliar with the book, the authors have put together an optimistic, readable book about arteriosclerotic heart diseases. The book is in four parts; first telling the danger of various factors in arteriosclerotic heart disease; the second tells how to overcome these factors to prevent disease; third shows recovery is possible from arteriosclerotic disease; and the fourth shows how planned living can prevent and help this disease.

There is an introduction by Paul Dudley White, M.D., and an extensive table of various foods and their nutrient values.

ALVIN J. HALEY, M.D.
Fort Wayne

THE THYMUS

Ciba Symposium, in honor of Sir McFarlane Burnet; edited by G. E. W. Wolstenholme and Ruth Porter; Little, Brown & Co., Boston, 1966; 538 pages; numerous illustrations; \$15.00

There was a time (not so long ago) when the thymus was considered a vestigial organ devoid of any use. The picture has been changing dizzily. More than two dozen prestigious participants discuss extensively the actions controlled by this gland. Dr. Burnet, the Nobel Laureate of "Self" and "Unself", presided and participated animatedly.

Does the immune mechanism really consist of two parts? Does the original stem cell produce the thymus controlling cellular immunity and also another central lymphoid organ manufacturing antibodies? Are the patches of Peyer in the human equivalent to the Organ of Fabricius in the fowl? There is good evidence that such is the case!!

What does the mast cell do? Where does leukemogenesis have its inception? How does the autoimmune concept become clarified? All are basic problems rapidly emerging from the fogs of uncertainty into the present and certain to modify profoundly the future.

As usual, the binding and editing are impeccable; the printing very clear and the price well within bounds of reason. An outstanding volume recommended for reading by all members of the medical profession.

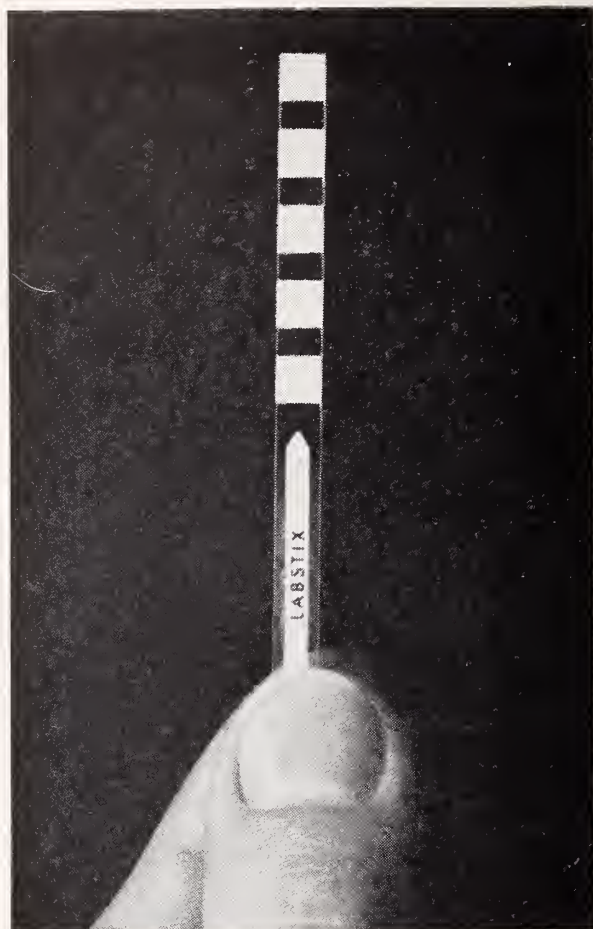
ARNOLD LIEBERMAN, M.D.
New York, N. Y.

HANDBOOK OF OCULAR THERAPEUTICS AND PHARMACOLOGY

Ellis & Smith, The C. V. Mosby Co., St. Louis, Mo., 1966.

This little handbook is actually two books under one cover. The first and larger section is devoted to therapy; the second to pharmacology.

The first section consists of chapters on the general principles of eye therapy, the steroids, the antibiotics, agents affecting the autonomic nervous system and therapy in eye surgery. These are



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

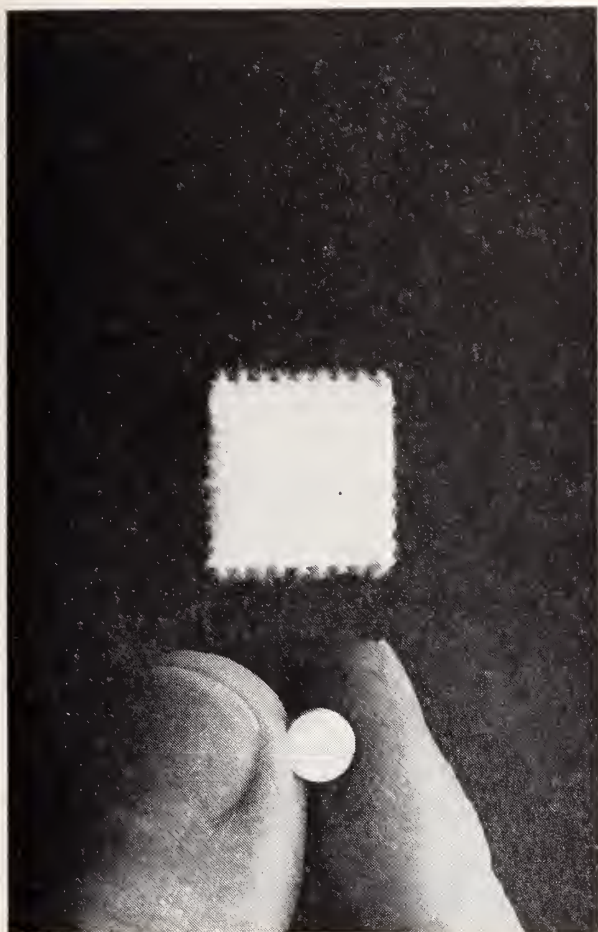
AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514



Ames

Note: AMERICAN HOSPITAL FORMULARY SERVICE
CATEGORY NUMBER 36:88

40167



...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. “Negatives” may help rule out suspected abnormalities over a broad clinical range and are important for the patient’s record.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514



Note: AMERICAN HOSPITAL FORMULARY SERVICE
CATEGORY NUMBER 36:88

40167

followed by chapters summarizing the treatment of most ocular diseases.

The section on pharmacology includes most of the drugs in current use in ophthalmology. They are presented alphabetically with concise descriptions of uses, action, reactions, contraindications and proper dosage. A separate schedule of pediatric dosage is included at the end of the sections.

The present and ever-increasing number of drugs used in ophthalmology makes it impossible for the practicing ophthalmologist to remember all of the pertinent information regarding them. This book provides an accurate time-saving reference. The authors have achieved their purpose in writing it and are to be congratulated.

JAMES W. McEWEN, M.D.
Terre Haute

HISTONES—Their Role in the Transfer of Genetic Information

Ciba Symposium, edited by A. V. S. de Reuck and Julie Knight; In honor of the academician W. A. Engelhardt (USSR); Little, Brown & Co., Boston, 1966; 112 pages; \$3.50.

At the dawn of the era of modern medicine—i.e., the 1880’s—“nuclein” compounds began to be found. A. Kossel discovered and named the protamine compounds, “histones.” As late as 1928, this pathfinder wrote a bulky monograph on these compounds: very few persons read about them; the topic became forgotten. Then, within the last couple of decades, RNA and DNA were discovered and exact steric formulae were written for them.

The biochemists and geneticists stumbled onto the alerting fact that ALL cells of any given organism had in their nuclei (*each and everyone* of them) precisely identical quantities of RNA and DNA! Why did the undifferentiated zygote develop a gastrula and then a blastula and then go on to differentiate the various organ systems?

To everyone’s astonishment, it was found that it was the *histones* that had the property of combining with the phosphoric acid groups along both sides of the DNA double helix and inhibiting “these” genes but not “those.” How come? Why do other chemicals also have similar properties?

As a consequence, within the last five years, there has flared intense research work along just these lines. This little study group presents the summary of our present knowledge in this new area of a hitherto unsuspected frontier of knowledge. Obviously, this is a strictly dated, interim report which will be promptly *outdated* by the continuing efforts of the participants in this study group. However, I found it fascinating and instructive. For one thing, the answers here will bear on the why of *cancer*. . . .

As usual, the binding, printing and price are all beyond reproach.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

CONTACT DERMATITIS DUE TO SPANDEX

P. S. Porter and R. G. Somner, (Hitchcock Clinic, Hanover, N. H.)

Arch. Derm. 95:43-44, (Jan.), 1967.

Allergic contact dermatitis due to Spandex was seen in five

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes

Each tablet contains:

Potassium Iodide..... 195 mg.
Aminophylline..... 130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—except—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



women in two months. The dermatitis presented a characteristic distribution corresponding to the Spandex-containing portions of the Playtex bras. In each case, the patients also had positive closed patch test reactions to the Spandex and the rubber accelerator, mercaptobenzothiazole. This rubber accelerator or a related structure may be used in the manufacture of the Spandex.

ALLERGIC CONTACT-TYPE DERMATITIS DUE TO SPANDEX IN BRASSIERE

R. F. Dickey (Geisinger Medical Center, Danville, Pa.)

Arch. Derm. 95:89-90, (Jan.), 1967.

The new synthetic elastic fiber with the name of Spandex is being used with increasing frequency in wearing apparel and garments. A 68-year-old woman developed characteristic eczematous contact-type dermatitis due to Spandex in a brassiere. The qualities and uses of this new synthetic elastic fiber are reported.

UNDETECTED SITE OF UPPER GASTROINTESTINAL HEMORRHAGE LOCALIZED BY SELECTIVE ARTERIOGRAPHY

G. Annes, L. Caplan, and H. Heimlich (111 E. 210th St., Bronx, N.Y.)

Arch. Surg. 94:44-45, (Jan.), 1967.

A patient with massive upper gastrointestinal bleeding and a normal gastrointestinal series had to be explored because of persistent or uncontrollable blood loss. The stomach and duodenum were opened but no site of bleeding could be identified and a pyloroplasty was performed. The patient, however, continued to bleed. Percutaneous selective arteriography of the celiac and superior mesenteric trunks with a subselective catheterization of the gastric artery demonstrated contrast leaking from the left gastric artery into a shallow fundal ulcer. Reoperation confirmed the findings, the vessel was ligated, and a wedge resection of the ulcer was performed. Thus, a superficial ulceration with erosion into a left gastric artery branch in an area difficult to examine by ordinary roentgenographic means was identified and curative surgery was performed.

GANGRENE OF THE HAND FOLLOWING INTRA-ARTERIAL INJECTION

D. L. Hager and J. N. Wilson (326 W. 23rd St., Los Angeles)

Arch. Surg. 94:86-89, (Jan.), 1967.

The intra-arterial injection of medications in the upper limb with resultant ischemia and gangrene is not an uncommon problem. Three cases involving amobarbital sodium, meperidine and promethazine, and promazine are reported. The clinical picture was quite characteristic. Immediately following the injection, the patients complained of burning pain in the hand. Signs of arterial insufficiency rapidly developed. The ischemia is apparently due to vessel wall damage with resultant thrombosis. Methods of treatment were only partly effective.

JAUNDICE AND ORAL CONTRACEPTIVE DRUGS

J. M. Orellana-Alcalde (Division of Medicine, Univ. Medical School, Santiago, Chile) and J. P. Dominguez

Lancet 2:1278-1280, (Dec. 10), 1966.

Fifty patients had cholestatic jaundice in association with the use of oral contraceptive drugs. The clinical, biochemical and microscopic findings bore a strong resemblance to those in cholestatic jaundice of pregnancy. Since the action of oral contraceptive steroids is said to mimic the hormonal environment of pregnancy, the cholestatic jaundice due to oral contraceptive drugs

and the cholestatic jaundice of pregnancy may have the same etiological basis.

HEREDITARY SPHEROCYTOSIS
IN 100 CHILDREN

H. C. Krueger and E. O. Burgert, Jr. (Mayo Clinic, Rochester, Minn.)

Mayo Clin. Proc. 41:821-830, (Dec.), 1966.

Historical and clinical data are presented on 100 consecutive pediatric patients with hereditary spherocytosis; two cases are given in detail. Fifty-seven patients were boys and 43 were girls. It was found that anemia was the most frequent chief complaint, although 64 patients initially had a normal hemoglobin value; splenomegaly was detected on initial examination in 79 patients; serum bilirubin was increased in 49 of 86 patients; spherocytes were found in 99 of 100 patients, ultimately in all cases, and osmotic fragility was increased in 77 of 91; reticulocytosis occurred in 82 of 92 patients, indicating greater frequency of hemolytic processes than aplasia of erythropoietic tissue; the spleen at operation was usually two to four times normal size; no significant infectious problems were encountered under five years of age regardless of age at splenectomy. For hereditary spherocytosis, splenectomy should be performed if the child has recurrent severe anemia or crises at any age, even under two years, or has cholelithiasis diagnosed at any age. Also, splenectomy is justified in the child beyond two years of age when anemia, splenomegaly, or icterus is present.

TREATMENT OF VOLVULUS OF THE
SIGMOID COLON AND CECUM

H. R. Nay and J. P. West (57 E. 93rd St., New York)

Arch. Surg. 94:11-13, (Jan.), 1967.

Volvulus of the colon requires prompt treatment to relieve obstruction and to prevent necrosis and perforation. Reduction of sigmoid volvulus, using sigmoidoscope and rectal tube, is safe and successful in a high percentage of cases; failure requires prompt operative detorsion. Primary resection is indicated when necrotic bowel is present; a Mikulicz procedure is often indicated. Most patients with sigmoid volvulus should have elective resection after proper bowel preparation. Cecal volvulus requires prompt operative correction; with viable bowel, reduction and fixation are adequate. In 26 episodes of colonic volvulus, there was one death in a patient with a gangrenous, perforated cecum.


METRONIDAZOLE IN AMEBIC DYSENTERY
AND AMEBIC LIVER ABSCESS

S. J. Powell et al. (Dept. of Medicine, Univ. of Natal, Durban, South Africa)

Lancet 2:1329-1331, (Dec. 17), 1966.

The effect of three schedules of metronidazole was assessed in 56 adult male African patients with acute amebic dysentery. In the highest dosage of 800 mg. thrice daily for ten days, 22 out of 25 patients were apparently cured; in one rectal ulcers persisted although *E. histolytica* was no longer demonstrable; in two there were parasitic failures. Ten patients with proved amebic liver abscess also received this dosage and all were cured. Slight electrocardiographic T-wave changes of doubtful significance occurred in four instances but there was no other evidence of toxicity or of side effects. Tolerance was good. Further evaluation is indicated since this trial suggests that metronidazole, when given in a sufficiently high dosage, is an effective, direct-

removes the mental blur



that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s

Solfoton Capsules (yellow and brown)
100s, 500s, 1000s

Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

acting amebicide in the bowel and the liver, with little significant toxicity.

CHROMOSOMES AND HUMAN PREGNANCY WASTAGE

H. A. Thiede and S. Metcalfe (Univ. of Rochester School of Medicine and Dentistry, Rochester, N.Y.)

Amer. J. Obstet. Gynec. 96:1132-1138, (Dec. 15), 1966.

Chromosome studies were completed on 91 human abortions while investigating the cytogenetic aspects of the problem. Consistent chromosome aberrations were found in 24 of 54 spontaneous abortions and in one of the 37 therapeutic abortions. The frequency of abnormal karyotypes was highest in pathological ova. Comparison of the sex chromatin and the gonosomes of placental specimens revealed only an 84% occurrence; this poor correlation was attributed to the difficulty in interpreting the chromatin pattern of placental nuclei plus a nine percent incidence of an XO karyotype among the spontaneous abortions. It appears that the results of studies of the primary sex ratio based on the sex chromatin test alone are misleading.

EARLY TREATMENT OF PHENYLKETONURIA

J. L. Kennedy, Jr., et al. (300 Longwood Ave., Boston)

Amer. J. Dis. Child. 113:2-5, (Jan.), 1967.

Four years' experience with the dietary treatment of phenylketonuria (PKU) from the newborn period is described. Phenylalanine requirements for these infants are given; various factors affecting phenylalanine requirements are discussed. On a low phenylalanine casein hydrolysate diet, 13 infants with severe PKU and six infants with a milder type have maintained mental development comparable to normal children of their age for periods up to four years. This development was attained with mean blood phenylalanine levels (6 mg/100 ml to 10 mg/100 ml) above those usually considered desirable for treatment; some of the milder cases of PKU can be managed with a low-protein diet alone. The major complication in patients treated with low phenylalanine diets was hunger. The phenylalanine in the casein hydrolysate given to these children makes up about one half of their total phenylalanine intake; this severely restricts the type and amount of supplemental foods which may be offered. The fact that these patients appear normal at ages two to four does not allow a firm prediction of their later intellectual abilities.

DEVELOPMENT OF RESISTANCE OF GONOCOCCI TO PENICILLIN: AN EIGHT-YEAR STUDY

C. R. Amies (Ontario Dept. of Health, Box 9000, Toronto)

Canad. Med. Assoc. J. 96:33-35, (Jan. 7), 1967.

During the last eight years, 5,700 strains of *Neisseria gonorrhoeae* were isolated and tested for sensitivity to penicillin and sulfadiazine. At the beginning of the study, 63% of the strains tested were sensitive to a concentration of 0.01 unit of penicillin per milliliter of diluent. Since then, the gonococcus has gradually developed resistance to this antibiotic until 27% of the strains isolated are now resistant to a concentration of 0.3 unit/ml, and eight percent are resistant to 1.0 unit/ml. To overcome this degree of resistance, it is necessary to give a soluble penicillin preparation intramuscularly in very high dosage (2-8 million units). There is an urgent need for a satisfactory substitute for penicillin in the treatment of gonorrhea; none has yet been found. ◀

Tandearil® oxyphenbutazone

Therapeutic Effects: Tandearil is a nonhormonal compound which may rapidly resolve inflammation and help restore normal joint function. Its action does not affect pituitary-adrenal function or impair immune responses. Its value in osteoarthritis is especially noteworthy because this disorder responds inconsistently to steroids and is often resistant to salicylates. Further, indomethacin is limited only to osteoarthritis of the hip, whereas oxyphenbutazone is effective in all forms of the disease.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Osteoarthritis: The initial daily dosage in adults is 300-600 mg. in divided daily doses. When improvement occurs, dosage should be decreased to the minimum effective level; this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

For complete details, please refer to full prescribing information. 6562-VI(B)R

Availability: Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps osteoarthritic
joints move again



3 out of 4 osteoarthritics com-
pletely or markedly improved

Please see ad-
joining page for
brief prescribing
summary.

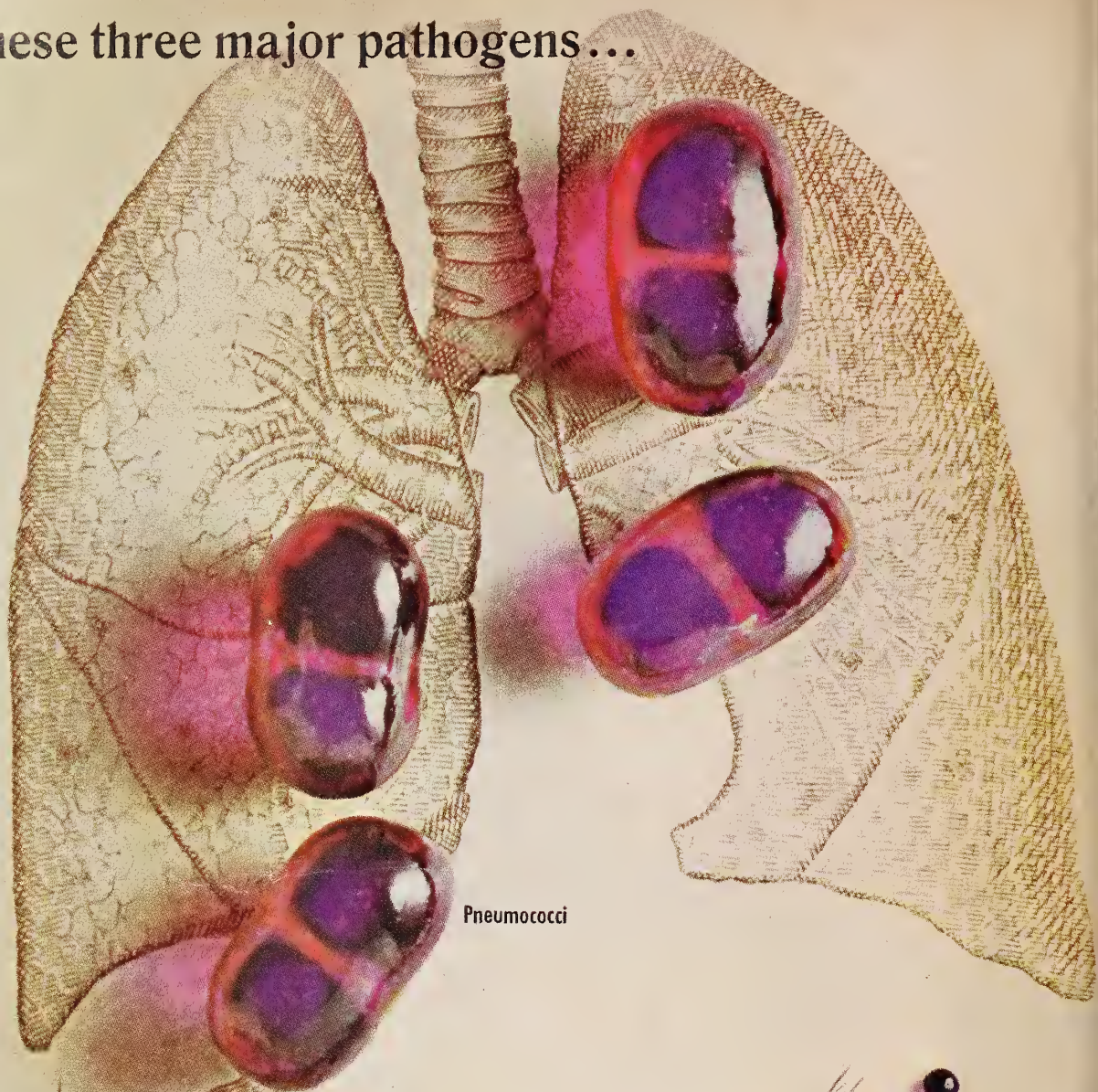
Sperling, I.L.: 3 Years' Experience
with Oxyphenbutazone in the
Treatment of Rheumatic Disorders,
Applied Therapeutics 6:117, 1964.

76.9% of 407 patients

Watts, T.W., Jr.: Treatment of Rheu-
matoid Disorders with Oxyphenbu-
tazone, Clin. Med. 73:65, 1966.

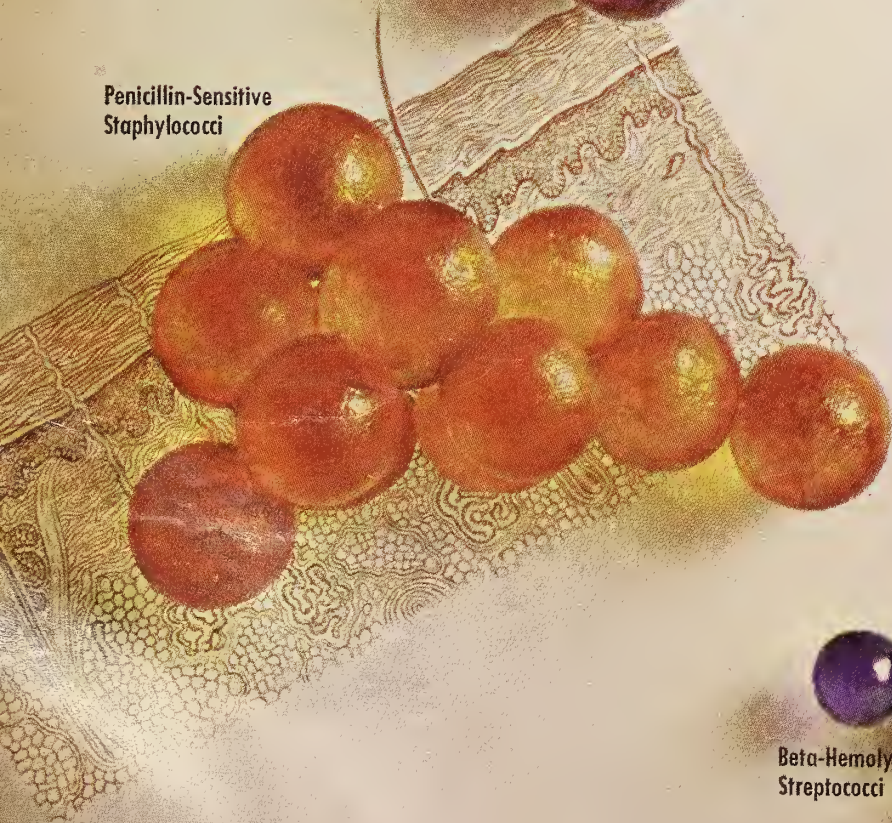
84.6% of 39 patients

Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



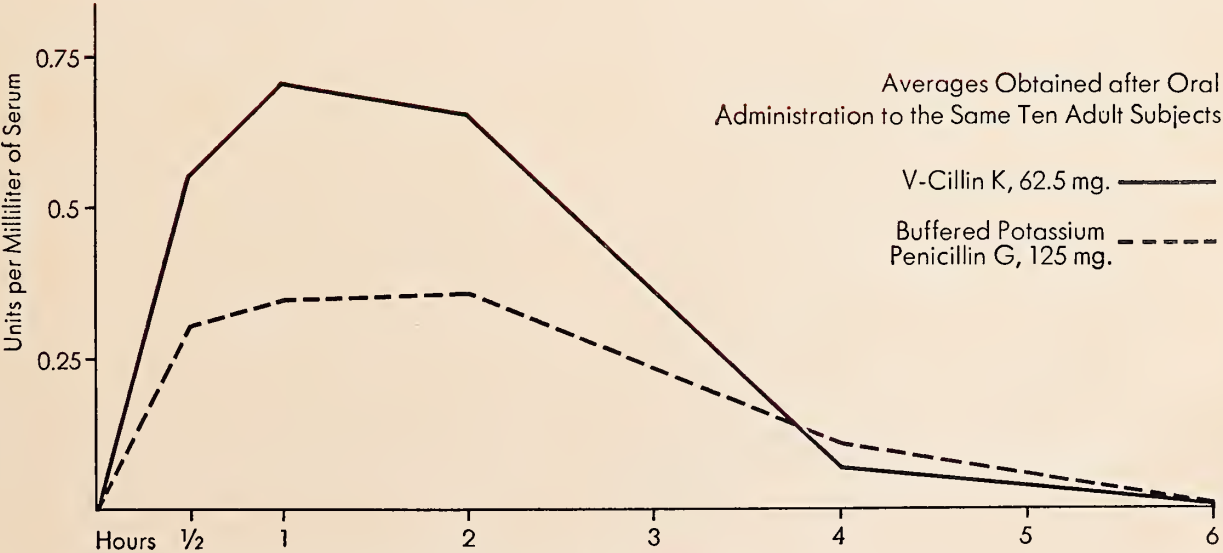
V-Cillin K[®] provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive)		Streptococcus, Group A		Diplococcus Pneumoniae	
	MIC (mcg./ml.) Median	Range	MIC (mcg./ml.) Median	Range	MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K[®]  700636
Potassium Phenoxyethyl Penicillin

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxy-methyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxyethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly



Smith Kline & French Issues its "Catalog of Services for 1967-68"

Smith Kline & French Laboratories has just issued its "Catalog of Services for 1967-68." The 36-page booklet lists medical films, booklets, periodicals, medical color television, speakers bureau information and a cardiopulmonary resuscitation training program, all of which are available from SK&F.

A free copy of the catalog may be obtained from the SK&F representative or by writing the Services Department E-10, Smith Kline & French Laboratories, 1500 Spring Garden St., Philadelphia 19101.

Dr. Murray Makes Address

Dr. William E. Murray, New Castle, recently presented a talk on the history of the New Castle State Hospital to the American Business Women's Association there.

"Indentation Tonometry Technique in Glaucoma Detection," New Film

The U. S. Public Health Service announces a motion picture film on "Indentation Tonometry Technique in Glaucoma Detection" for free short-term loan to medical organizations. It is a 16 mm, color, sound film and runs for eight minutes. Its purpose is to depict the use and maintenance of the tonometer in performance of the glaucoma screening test.

Write Public Health Service Audiovisual Facility, Atlanta, Georgia 30333, Attn: Distribution Unit.

Dr. Powell is Speaker

Dr. Richard C. Powell, Indianapolis, spoke on "Hyperlipemia—Another Disguise of Diabetes" at a recent meeting of the Clinical Society of the Indianapolis Diabetes Association.

Dr. Irvine H. Page Named 1967 Passano Foundation Laureate

Irvine H. Page, M.D., is the 1967 Passano Foundation Laureate. The presentation of the \$5,000 award was made at a June 19 reception and dinner at the Traymore Hotel, Atlantic City, during the American Medical Association's annual convention.



Dr. Page, past-president of the American Heart Association, member, trustee and fellow of many professional societies, editor-in-chief of the journal *Modern Medicine*, author of eight books, and research consultant to the famous Cleveland Clinic, received the award for his outstanding contributions to the understanding of the pathogenesis and pathophysiology of hypertension, a disease condition related to many illnesses.

The Passano Foundation was formed late in 1943 with the sole purpose the encouragement of the medical sciences, and particularly research with medical applications. The foundation is sustained by annual contributions from The Williams & Wilkins Company, publishers of books and periodicals in medicine and the allied sciences.

Six of the Passano Laureates have subsequently received the Nobel prize for their researches.

American Medical Writers' 27th Annual Meeting Set for September

The 27th Annual Meeting of the American Medical Writers' Association (AMWA) will be held at the Palmer House in Chicago, September 21 to 24.

The program is designed for both physicians and journalists with interest in the field of medical writing. Attendance is open to both members and non-members of AMWA.

A major feature of the meeting is a workshop in which manuscripts submitted in advance are critically reviewed by panels of editors. Among special sessions this year will be discussions of educating medical writers, ethics in medical journalism, new methods of approaching the literature, drug information as viewed by government, industry and the journals, and medical news for the physician.

Further information may be obtained from AMWA, Post Office Box 267, Arlington, Va. 22210.

Dr. Dupler is Speaker

Dr. Lee F. Dupler, Frankfort, was guest speaker at the recent meeting of the Frankfort branch of the American Association of University Women. He spoke on internal medicine.

PMA Awards 20 \$1,000 Grants to United States Medical Students

Twenty medical students at 14 U. S. medical schools have been awarded grants by the Pharmaceutical Manufacturers Association Foundation to enable the pursuit of training in clinical pharmacology. The grants are for \$1,000.

The student assisting program is complementary to the Foundation's faculty development awards. Both programs are designed to develop more clinical pharmacologists, who are needed for the evaluation of the new and more complex drugs.

Dr. Ingram Lectures

Dr. Richard Ingram, Montpelier, recently presented a lecture on the social and personal hazards of venereal diseases to Montpelier High School students.



SUSAN T. BERTRAND, 18, New Albany high school senior, was presented the AMA's top honor at the 18th International Science Fair in San Francisco by Dr. Dwight L. Wilbur, a member of the AMA Board of Trustees and master of ceremonies at the Health Awards Banquet. Susan won for her exhibit on "Electrophoretic Analysis of Blood Serum," from among 425 finalists from 229 regional fairs.

Indiana Teenager Wins AMA Award at 18th International Science Fair

Winner of one of the two top AMA awards at the 18th International Science Fair in San Francisco, May 10-13, was Susan True Bertrand, 18, a senior in New Albany High School.

She was selected from among 425 finalists for her work with "Electrophoretic Analysis of Blood Serum," which studies the electrophoretic differences in the blood of various mammals and shows how protein concentration in the blood is an indication of health.

Judges were members of the AMA Council on Scientific Assembly, chaired by Dr. Lee E. Farr, Houston, Tex. Susan's award, and that of her co-winner, Stephen R. Igo, Winterset, Ia., was presented at the health awards banquet by Dr. Dwight L. Wilbur, San Francisco, member of the AMA Board of Trustees. It consisted of a citation and an all-expense trip to the AMA's 116th Annual Convention, June 18-22, in Atlantic City.

The awards program is an annual feature of the fair and its hosts are the AMA, the American Dental Association, the American Pharmaceutical Association and the American Veterinary Medical Association.

Susan competed with 425 student-finalists from 229 regional and state science fairs in 46 states, the District of Columbia, Canada, Germany, Japan, Nicaragua, the Philippines, Portugal, Puerto Rico, Sweden, Switzerland and Turkey.

Dr. Yegerlehner Joins Purdue Center

Dr. Roscoe S. Yegerlehner, Kentland, has accepted a position with the Purdue Health Center. He began his work in March.

PMA Foundation Awards More than \$600,000 for Scientific Research

Voluntary contributions have enabled the Pharmaceutical Manufacturers Association Foundation to award more than \$600,000 during the past 18 months for scientific and medical research.

The awards, according to the PMA Foundation's 1966 annual report, include grants of \$435,000 for research in toxicology and drug evaluation; \$75,000 for sponsorship of a number of workshops, conferences, and symposiums; \$95,000 for the establishment of two training programs in clinical pharmacology and \$30,000 for continuing support of a program to study tissue reactions to drugs.

It was announced earlier this month by E. Gifford Upjohn, M.D., chairman of the Board of Directors of the Foundation, that the PMA Foundation, since its establishment two years ago, has thus far received contributions of nearly \$1,000,000 from PMA member firms, other industry-related groups and individuals.

In announcing the past year's activities, the report stresses that support for the fields of toxicology and clinical pharmacology are "initial" areas of PMA Foundation interest. Other possibilities for support will be considered, according to the report, "as more funds become available."

The report states clearly, however, that one activity the Foundation will not undertake is research on specific drugs. "Its concern is rather within the broad field of therapeutics," explains the report, "using its resources to pioneer new studies, new methodologies, new directions and guidelines."

Specific projects approved during the past year and the amounts appropriated include two workshops on drug metabolism, one at New York University (\$18,000), the other at George Washington University (\$20,090); an interdisciplinary conference on immunology-pharmacology at the National Academy of Science-National Research Council (\$11,800); a conference on clinical investigations at the American College of Cardiology (\$5,000); and support for an international symposium on comparative pharmacology (\$3,000).

Also, slightly more than \$30,000 has been allocated to support the Registry of Tissue Reactions to Drugs at the Armed Forces Institute of Pathology. This activity is supported and co-sponsored along with the American Medical Association, the Food and Drug Administration and the National Institutes of Health.

Dr. Dunbar Speaks

Dr. Fred E. Dunbar, Marion, spoke on "Hypnosis" at a recent meeting of the Marion Jaycee wives.

Doctor's Hobby Featured

Dr. Lall G. Montgomery, Muncie, was featured recently in the April issue of *The Columbian*. The article discussed Dr. Montgomery's beautiful daffodils, one of his many hobbies.

Mead Johnson Award Winners

Harry W. Gordon, M.D., Methodist Hospital, and Donald J. Kerner, M.D., Indiana University Medical Center, have been

selected as 1967 Merd Johnson Award winners. They will take their residency at Methodist Hospital, Indianapolis.

Dr. Gillespie Presents Award

Dr. Charles F. Gillespie, Indianapolis, retiring Chairman of District V of the American College of Obstetricians and Gynecologists, presented a special award in Louisville recently to Dr. Laman A. Gray for an exhibit portraying the Ephraim McDowell House.

The exhibit is devoted to photographs of the original McDowell House in Danville, Kentucky, together with memorabilia of Dr. McDowell's practice.

Dr. Harris Elected

Dr. James C. Harris, Carmel, has been re-elected president of the Hamilton County Heart Association.

AAMA Announces Availability of Medical Assistant Scholarships

Loans for medical assistant training are now available from the Maxine Williams Scholarship Fund, sponsored by the American Association of Medical Assistants.

Each loan is for \$300. As AAMA assumes all administrative costs, there is no interest rate. Repayment may be made after the student is employed.

Anyone who is a high school graduate, and wishes to take formal training, is eligible to apply for a loan. Application blanks are available from AAMA headquarters, 510 N. Dearborn St., Chicago, Ill. 60610.

The fund, named in honor of AAMA's first president, is supported entirely by private contributions. It was established to encourage those wishing to become medical assistants to take formal training, preferably at a school which offers a two-year course.

Dr. Maschmyer is Speaker

Dr. Robert H. Maschmyer, Logansport, talked on the alcoholic program at Logansport State Hospital at a recent meeting of the Cass-Carroll Medical Assistants.

John A. Hartford Foundation Announces Grants to Hospitals

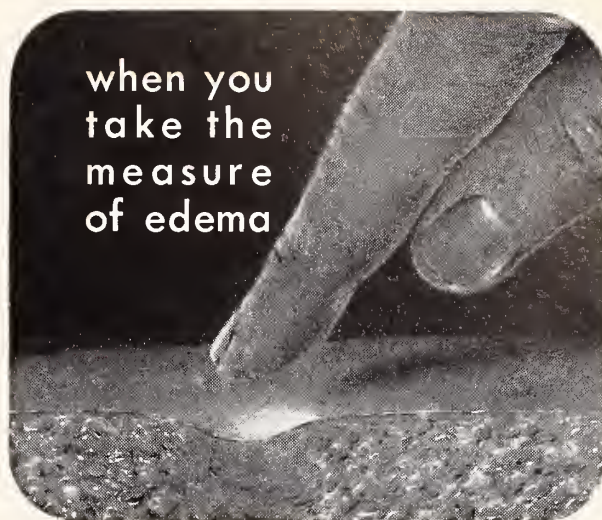
The John A. Hartford Foundation announces its grants during 1966 totaled \$14,462,862 and included \$219,477 to Indiana University Foundation for the Riley Hospital experimental and clinical studies of degeneration and regeneration in the central nervous system, and \$49,107 to Indiana University Foundation to study the nature and physiological effect of soft tissue fluoride.

Doctors Discuss Coronary Unit

Drs. Fred Kuipers, Lafayette, **Thomas M. Brown**, Muncie and **Berj Antreasian**, Indianapolis, were guest speakers at a recent meeting of the Fulton County Medical Society. Dr. Brown discussed the concepts of coronary intensive care while Dr. Antreasian's main topic was personnel training for care of such patients. Dr. Kuipers discussed the equipment and space requirements for coronary care.

Dr. Sadusk Appointed

Dr. Joseph F. Sadusk, Jr., distinguished medical educator, one-time Medical Director of the Food and Drug Administration, and recently Professor of Medicine and Associate Dean of the Johns Hopkins University School of Medicine, has been appointed as Vice President for Medical Affairs at Parke, Davis & Company.



... introduce your patient to

aQUATAG[®]
(BENZTHIAZIDE)

AQUATAG (Benzthiazide) is a potent, orally active, nonmercurial, diuretic agent. It is effective orally in producing diuresis in edema states, where it is therapeutically comparable to mercurials given parenterally. AQUATAG (Benzthiazide) is mildly antihypertensive in its own right and enhances the action of other antihypertensive drugs when used in combination.

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

WARNINGS: Use with caution in the presence of renal disease as azotemia may be precipitated or increased. In patients with advanced hepatic disease, electrolyte imbalance may result in hepatic coma. Dosage of coadministered antihypertensive agents should be reduced by at least 50%. In cases of suspected electrolyte imbalance, serum electrolyte determinations should be performed and imbalance, if any, corrected. Stenosis or ulcer of small intestine have been reported with coated potassium formulas, and surgery has been required and deaths have occurred. Based on surveys of both United States and foreign physicians, incidence of these lesions is low and a causal relationship in man has not been definitely established. Until further experience has been obtained, the use of the drug in pregnant patients should be weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or dysfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties. Severe hepatic disease is a relative contraindication. (See "Warnings" above.)

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia (digitalis toxicity may be precipitated), hypochloremic alkalosis and hyponatremia may occur. Patients with cirrhosis should be observed for impending hepatic coma and hypokalemia. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Hepatic tetor, tremor, confusion and drowsiness are signs of impending pre coma and coma in patients with cirrhosis. Insulin requirements may be altered in diabetes. AQUATAG (benzthiazide) should be used with caution post-operatively as hypokalemia is not uncommon. Potassium supplementation may be advisable pre- and post-operatively. There have been occasional reports of thrombocytopenia, leukopenia, agranulocytosis, aplastic anemia and precipitation of acute pancreatitis or jaundice.

Before prescribing or administering, read the package insert or file card available on request. Available as 25 or 50 mg. scored tablets. Request clinical samples and literature on your letterhead.

S.J. TUTAG
& COMPANY
Detroit, Michigan 48234

Dr. H. Frank Fraser Named Senior Physician at Eli Lilly

H. Frank Fraser, M.D., has been named a senior physician in the medical research division of Eli Lilly and Company, Indianapolis-based pharmaceutical manufacturer.



Born in Saskatchewan, Canada, Dr. Fraser was graduated in 1921 from high school in Bellingham, Washington. In 1925 he received a Bachelor of Arts degree in economics from the University of Washington. He studied premedicine at the University of Chicago and in 1932 earned his Doctor of Medicine degree from Cornell University.

Before joining Eli Lilly and Company in November, 1963, Dr. Fraser spent 31 years as a commissioned

officer in the U. S. Public Health Service, which in 1962 awarded him the Meritorious Service Medal. For 15 of these years, he was engaged in research on the addiction liability of drugs and for 11 years was associate director of the National Institutes of Health Addiction Research Center in Lexington, Kentucky. He is recognized throughout the world as an authority on drug addiction.

In the Lilly Laboratory for Clinical Research, Dr. Fraser is responsible for studies related to the addictive properties of drugs and for research in the fields of barbiturate therapy, analgesia and psychotherapeutics.

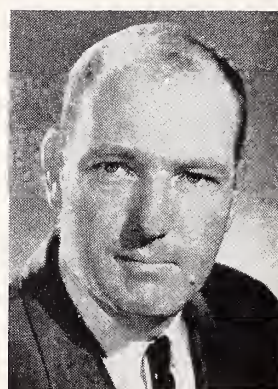
Dr. Fraser is a member of the American Chemical Society, the American Medical Association, the American Society for Pharmacology and Experimental Therapeutics, and the American Therapeutic Society.

Dr. Brakel on Panel

Dr. Frank Brake!, Evansville, recently lead a panel discussion on "How Does the Doctor Look at the Dietitian" at a meeting of the Southwest Indiana District Dietetic Association at Deaconess Hospital.

Dr. John A. Galloway Named Senior Physician at Eli Lilly

John A. Galloway, M.D., has been named a senior physician in the medical research division of Eli Lilly and Company, Indianapolis-based pharmaceutical manufacturer. He handles correspondence with physicians relating to Lilly products for the treatment of diabetes and hypoglycemia.



A native of Omaha, Nebraska, Dr. Galloway was graduated in 1946 from St. Albans School for Boys in Washington, D. C. In 1950 he received a Bachelor of Arts degree from the University of Pennsylvania, in 1956 the University of Nebraska College of Medicine awarded his Doctor of Medicine degree, and in 1960 he earned a Master of Science degree in medicine from Temple University.

Before joining Eli Lilly and Company in 1962, Dr. Galloway was a member of the staff of Temple University and was in private practice in York, Pennsylvania. He served in the United States Army from 1950 to 1952.

Dr. Galloway is a member of the American Federation for Clinical Research; the American Diabetes Association; the American College of Physicians; the New York Academy of Sciences; and Phi Rho Sigma, professional medical fraternity.

Doctors Elected

Dr. Charles L. Wise, Camden, has been elected chairman of the board for the Carroll County Board of Health. Also elected were **Drs. Max R. Adams**, Flora, vice-chairman and **T. Neal Petry**, Delphi, secretary.

SKF Publishes New Book on "Drug Abuse: Escape to Nowhere"

Smith Kline & French Laboratories announce the publication of a book "Drug Abuse: Escape to Nowhere" for the purpose of acquainting teachers with the problem of drug abuse involving juveniles.

The 104-page book was produced with the cooperation of the National Education Association. Copies may be obtained at \$2.00 each (quantity discounts available) by writing the Association at 1201 Sixteenth St., N. W., Washington, D. C. 20036.

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs
for a few days health vacation
—the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.



HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate
Medical Director

Dr. Jones Named

Dr. Gordon C. Jones, Indianapolis, has been named president of the medical staff of Community Hospital for the coming year. He took office on March first.

Other officers named were Drs. Wayne H. Thompson, Indianapolis, vice-president, and Thomas E. Reed, Indianapolis, secretary-treasurer.

Dr. Girod is Speaker

Dr. Arthur H. Girod, Decatur, spoke on his experiences as a volunteer in a civilian hospital in Vietnam at a recent meeting of the Fort Wayne Area Chapter, American Red Cross.

Indiana Doctors Speak

Three Indiana doctors spoke at a coronary intensive workshop recently at Pulaski Memorial Hospital at Winamac. The speakers and their topics included: **Drs. Thomas Woerner**, Indianapolis, "Intensive Coronary Care Concepts"; **P. W. Rothrock**, Lafayette, "Personnel Training for Coronary Care" and **D. L. Frasier**, Kokomo, "Equipment and Unit Design for Coronary Care." **Dr. H. J. Halleck**, president of the Pulaski County Medical Society, presided.

Dr. Aust is Speaker

Dr. Charles H. Aust, Fort Wayne, was speaker at a recent meeting of the Fort Wayne Academy of Medicine. His subject was "Electrophoresis as Applied to Clinical Medicine."

Dr. Cantwell is Speaker

Dr. Edgar R. Cantwell, Vincennes, spoke on eye diseases and problems at a recent meeting of the Vincennes Jaycettes.

Dr. Dratz Appointed

Dr. Henry M. Dratz has been appointed director of the VA hospital at Indianapolis. Dr. Dratz comes to Indiana from a position as chief of staff of the Richmond, Virginia VA hospital.

Dr. Dratz New Director of Veteran's Administration Hospital

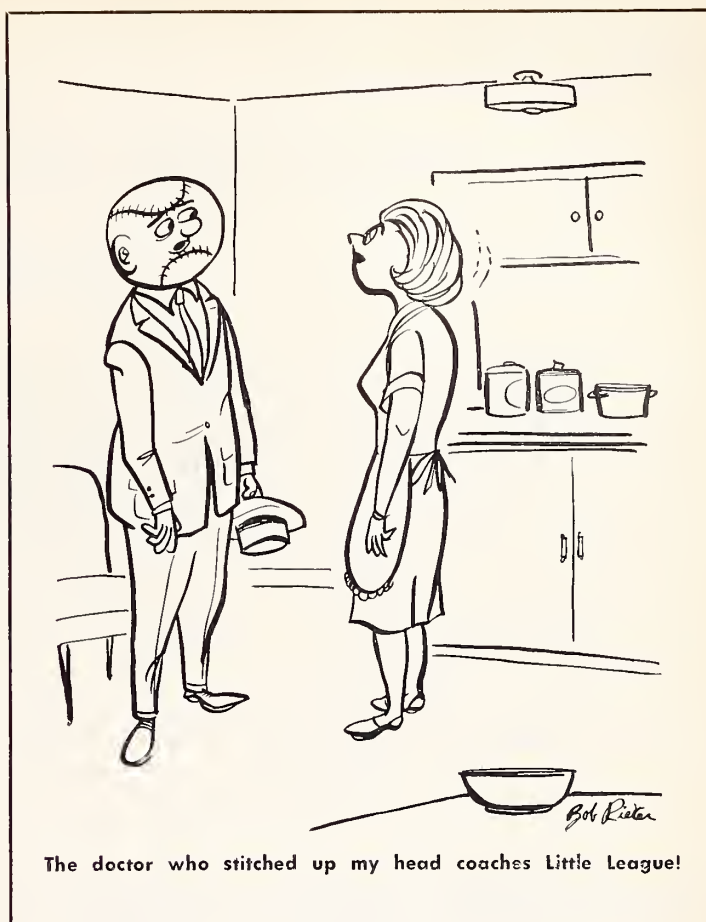
The new director of the Veteran's Administration Hospital, 1481 W. 10th Street, Indianapolis, is Dr. Henry M. Dratz. Dr. Dratz, 46-years-old, began his responsibilities at the V.A. Hospital in April.

He received his M.D. degree from Duke University in 1944. He entered the United States Army in 1951 and was discharged as a captain in December, 1952. From October '45 to August, 1950, he served his residency at Duke University, Durham, North Carolina.

Prior to accepting the V.A. responsibility here, he served as Chief of Neurosurgery at Albany, New York; chief of staff trainee at the Veteran's Administration Hospital in Bronx, New York and was chief of staff at the V.A. Hospital in Richmond, Virginia.

Dr. Carlson is Speaker

Dr. Milton R. Carlson, Portage, recently spoke at a Portage Chamber of Commerce meeting. His topic was additional medical training facilities.



5 Reasons Why INDIANA DOCTORS Recommend HANGER Prostheses...

1. HANGER is the oldest and largest prosthetic manufacturer in Indiana.
2. More people in Indiana wear HANGER Prostheses than any other make.
3. The HANGER organization has more employees and more certified fitters than any other prosthetic manufacturer.
4. HANGER wearers are guaranteed HANGER service and repairs at 39 HANGER offices from coast to coast.
5. HANGER research is working actively on new prosthetic developments for the benefit of all amputees.

Hanger
PROSTHESES

AIR CONDITIONED OFFICES
1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

More Light on Monilial Vaginitis

A. W. CAVINS, M.D.
Terre Haute

An interesting report on a bit of clinical research appears in *The Journal of the Florida Medical Association*, April, 1967, Vol. 54, No. 4, p. 337. As in trichomoniasis, resistance to cure and frequent recurrence may result from chronic infection in the sexual partner.

The author, Charles A. Gilpin, M.D., believes the organism is harbored chiefly in the seminal

vesicles, thus explaining why specimens from prostatic massage show a low incidence of positive culture for *Candida*, in contrast to the high incidence in condom specimens. Trial of oral Nystatin in 25 of these men proved ineffective. His summary follows:

One hundred cases of resistant monilial vaginitis in the female have been investigated. Semen specimens

from the mates, obtained during intercourse with a condom, have revealed *Candida* in all cases when plated onto Nickerson cultures.

Present methods for treatment in the male have proved wholly inadequate, so that the patient's only alternative is that of wearing a condom during intercourse, in which 15% of the males will have negative cultures in six months, or periodic retreatment of the female as she becomes re-infected. ◀

WANTED: Locations Physicians

GENERAL PRACTICE

Alfredo Q. Paje, Char Mac Hotel, 140 3rd Ave., S. E., Valley City, North Dakota
William Renforth, Borgess Hospital, 1521 Gull Road, Kalamazoo, Mich. 49001
Carlos M. Nuqui, 1133 N. Oakley Blvd., Chicago, Ill. 60622
Morris A. Osborn, 4817 Baltimore Ave., Philadelphia, Pa. (also *Industrial Medicine*)
John D. Annes, 5446 W. Gale St., Chicago, Ill. 60630

SPECIALISTS

Federico P. Vallesteros, 254 ½ Southmont Blvd., Johnstown, Pa. 15905—*Anesthesiology*
Velda J. Weber, 112 Sunset Dr., Belmond, Iowa 50421—*Anesthesiology*
Claude P. Hobeika, 2311 N. W. 174 Terrace, Opa Locka, Fla. 33054—*Ear, Nose and Throat*
Jack E. Gruender, 5530 N. 27th St., Apt., Milwaukee, Wis. 53209—*Internal Medicine*
Michael B. Mock, 502 University Park, Rochester, New York 14620—*Internal Medicine*

John H. Kohler, 1869 E. Thompson Rd., Indianapolis, Ind.—*Internal Medicine-Cardiology*
Thomas K. Hatthorn, 6244 Cary Ave., Cincinnati, Ohio 45224—*Internal Medicine*
Norman L. Ekberg, 750 Old Lancaster Rd., Berwyn, Pa. 19312—*Internal Medicine*
Gary Gene Gilbert, 108 Murdock Rd., Baltimore, Md. 21212—*OB-GYN*
William J. McVay, 308 Center Avenue, Mt. Pleasant, Pa. 15140—*Ophthalmology*
Ronald K. Bunten, 1601 E. Court St., Iowa City, Iowa 52240—*Orthopedics*
Hushang M. Payan, V. A. Hospital, Clarksburg, West Virginia 26301—*Pathology*
Stanley G. Hall, 97th General Hospital, APO New York, N. Y. 09757—*Pathology*
Jamil T. Azzam, P. O. Box 8434—Kuwait, Arabian Gulf—*Pediatrics*
Willis H. Marshall, Jr., 528 W. Cherry St., Cherokee, Iowa 51012—*Psychiatry*
Jay N. Bhore, 439 Wrightwood Ave., Chicago, Ill. 60614—*Psychiatry*
Ralph D. Froelich, 3566 Panama Dr., Westerville, Ohio 43081—*Psychiatry*
Trilok S. Khanna, 24 Stevens Street, Norwalk, Conn. 06852—*General Surgery*
Mostafa H. Bate, 1553 Virginia St., E., Charleston, West Virginia 25311—*Surgery*
Harry S. Weber, 112 Sunset Drive, Belmond, Iowa 50421—*Surgery*

Henry R. Hug, 28804 Grant, St. Clair Shore, Mich. 48081—*Thoracic and General Surgery*
Charles F. Barbarisi, South Main St., Wolfeboro, New Hampshire 03894—*General Surgery*
Frank M. Pugliese, Jr., 329 Cypress St., Philadelphia, Pa. 19106—*General Surgery*
Mahmoud Mousavipour, 8506 Garfield St., Bethesda, Md. 20000—*General Surgery*
Stefan H. Fromm, 3202 Harvard Road, Royal Oak, Mich. 48072—*General Surgery*
Kamal A. Sakkal, 3611 St. Famille St., Apt. 12, Montreal, Prov. of Quebec, Canada—*General Surgery*
Virgil L. Curry, 22 La Poterie St., Fort Bragg, North Carolina 28307—*Urology*
Gary R. Alford, 3415 N. Wishon, Fresno, Calif. 93704—*Urology*
Frederick P. Feder, Jr., 83 Valiant Dr., Rochester, New York 14623—*Urology*
Harvey Herberman, 1686-A Elm St., Fort Dix, New Jersey 08640—*Urology*

ADDITIONAL LOCATIONS

Rush County—CARTHAGE—population 1,026; located 14 miles from Rushville where hospital facilities are available. Hospitals located at Greenfield, 15 miles away and New Castle, 23 miles. Office space and equipment of the late Dr. George B. McNabb available. Northwestern Rush County without the services of a physician. Contact Mr. Frank Hampton, 307 N. Main St. or Mr. James Ellis, Carthage, Indiana 46115. ◀



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

FUTURE MEETINGS, SEMINARS, COURSES

"Basic and Clinical Aspects of Therapy in Advanced Cancer" Course

A course on the "Basic and Clinical Aspects of Therapy in Advanced Cancer" will be conducted at the University of Wisconsin Medical Center on October 16 to 21.

The purpose of the course is to demonstrate the practical clinical application of laboratory science discoveries in anti-cancer therapy. For further information write Dr. R. J. Samp, University Hospitals, Madison, Wisconsin, 53706.

Sixth Annual Southwide Lawyers Conference Set for August 9-13

The Sixth Annual Southwide Lawyers and Physicians Conference will be held from August 9 to 13, at Lake Junaluska, North Carolina. The program is acceptable for 12 accredited hours by the American Academy of General Practice.

For copies of the program and lodging information write Barry L. Rogers, Program Director, P. O. Box 67, Lake Junaluska, North Carolina 28745.

Legal Medicine Instruction Offered in Colorado this Summer

"Legal Medicine and the Elements of Medicolegal Litigation for Physicians and Lawyers" will be the subject of six independent self-contained weeks of instruction given by the Law-Science Academy of America at Crested Butte, Colorado this summer.

The first week is July 10 to 14, and the last week will be Aug. 14 to 18. Five mornings and two evenings will be devoted to classes; the afternoons will be free for recreational activities. For full particulars write Hubert Winston Smith, LL.B., M.D., Crested Butte, Colorado 81224.

University of Colorado Offers Seven Postgraduate Courses

The University of Colorado will conduct a five-day postgraduate course in pediatrics at Estes Park July 31 to August 4. The tuition fee is \$80.

Advance registration is necessary. Write Department of Pediatrics, 4200 E. Ninth Ave., Denver 80220.

Other postgraduate courses offered by the university include: Internal medicine, August 7-11; hospital medical staff conference, October 2-6; premature infant care, October 2-6; fractures and joint injuries, November 1-3; pediatric biochemistry, November 6-10 and modern concepts of allergy, December 6-8.

The above dates are subject to change. For further information and detailed programs, write The Office of Postgraduate Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver 80220.

Sixth Postgraduate Conference On Medical Aspects of Sports

The Sixth Postgraduate Conference on Medical Aspects of Sports will be conducted at Keaney Gymnasium, University of Rhode Island, Kingston, Rhode Island on August 17 and 18.

Write Dr. A. A. Savastano at the university for registration and program information.

American Academy of Orthopaedic Surgeons Sets Course on Sports

A special postgraduate course in sports medicine will be conducted by the American Academy of Orthopaedic Surgeons at the Skirvin Hotel, Oklahoma City, on August 14, 15 and 16.

A distinguished faculty will discuss a wide variety of subjects related to medical care of the athlete and especially those competing in the Olympic Games in Mexico City. For application forms and more information write Dr. Don H. O'Donoghue, 1111 N. Lee St., Oklahoma City 73103.

Gastroenterology Postgraduate Course Listed for November 2-4

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology at the Biltmore Hotel, Los Angeles, on November 2, 3, and 4.

The subject matter will cover recent advances in both the medical and surgical fields. For further information and enrollment write to the College at 33 W. 60th St., New York City 10023.

Rehabilitation Medicine Annual Session Will be Held in Florida

The 45th Annual Session of the American Congress of Rehabilitation Medicine will be held at the Americana Hotel, Bal Harbour, Florida on August 27 to September 1. Write to the Congress at 30 N. Michigan Ave., Chicago 60602, for program and other information.

Ninth National Conference on Medical Aspects of Sports Set

The Ninth National Conference on the Medical Aspects of Sports will be held in Houston, Texas, at the Hotel America on November 26.

The conference is open to nonmedical athletic personnel as well as interested physicians. Further information may be obtained by writing the Committee on the Medical Aspects of Sports, AMA, 535 N. Dearborn, Chicago 60610.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING

Date November 26-29, 1967

Place Houston, Texas

INDIANA HOSPITAL ASSOCIATION

Date Nov. 1-3, 1967

Place French Lick-Sheraton Hotel,
French Lick

INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 9-12, 1967

Place Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every month,
September through June

Place For location and program, inquire
Beatty Memorial Hospital, Westville

INDIANA NEUROPSYCHIATRIC ASSOCIATION

Date Second Wednesday of the month,
October through May, excluding
December

Place The Athenaeum, Indianapolis

INDIANA PHARMACEUTICAL ASSOCIATION

Date July 18-20, 1967

Place French Lick Sheraton Hotel,
French Lick

INDIANA STATE NURSES ASSOCIATION

Date Oct. 12-14, 1967

Place French Lick-Sheraton Hotel,
French Lick

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER

Date May 17-18, 1968

Place Stouffer Inn, Indianapolis

BONE AND JOINT CLUB

Date October 18, 1967

Place Athenaeum, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE

Date March 26-28, 1968

Place Indianapolis

INDIANA ACADEMY OF OPHTHAL- MOLOGY AND OTOLARYNGOLOGY

Date May 1-2, 1968

Place Culver Inn, Culver

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.

Date December 2, 1967

Place Indianapolis Motor Speedway
Motel, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Date January 10, 1968

Place Stouffer Inn, Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS

Date May 25-26, 1968

Place Marott Hotel, Indianapolis

HARDING HOSPITAL, Inc.

(Formerly Harding Sanitarium)

WORTHINGTON

OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

GEORGE T. HARDING, M.D.

Medical Director

JAMES L. HAGLE, M.B.A.

Administrator

Phone: Columbus 614-885-5381



when he just can't sleep
Tuinal[®]

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, 1½, and 3-grain Pulvules[®]**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206



Deaths



Elton R. Clarke, M.D.

Dr. Elton R. Clarke, 73, a Kokomo physician for 37 years and president of the Indiana State Medical Association in 1957, died May 15 at his home.

Dr. Clarke, graduated from the Rush Medical College in 1923, is the only Howard County man to hold the ISMA presidency. He was a veteran of World War I and a native of Indianapolis. He had served as secretary-treasurer and president of the Howard County Medical Society, a founder, director and life member of the Indiana Academy of General Practice, a delegate and life member of the American Academy of General Practice and a member of the ISMA Council five years (two years as chairman).

Dr. Clarke was a member of the staffs of the St. Joseph Memorial, Good Samaritan and Howard Community Hospitals, a member of the St. Joseph Hospital board of governors many years and taught in the nurses training school at St. Joseph's over a long period. He also served two terms as coroner of Howard County, one term as county health commissioner and several terms on the ISMA Grievance Committee and Medical Education and Licensure Commission. He was made a Senior Member of ISMA in 1964.

Ralph K. Arisman, M.D.

Dr. Ralph K. Arisman, 61, South Bend general practitioner, died April 12 in St. Joseph's Hospital there.

Dr. Arisman, graduated from the I.U. School of Medicine in 1935, practiced medicine in Elkhart for several years during the 1930's and had lived in South Bend for the past 31 years. He was a member of the St. Joseph County Medical Society and served as staff physician at St. Joseph's Hospital for the last two years.

M. Joseph Barry, Sr., M.D.

Dr. M. Joseph Barry, Sr., practicing physician in Indianapolis for 55 years, died May 15 in Rochester, Minn., where he had made his home for the last two years. He was 86.

Dr. Barry, born in Indianapolis, was graduated from the I.U. School of Medicine in 1908 and entered private practice in 1910. He was several times chief of the medical staff at St. Vincent's Hospital, a professor emeritus of clinical medicine at the I.U. medical school and from 1932 to 1942 was president of the City Board of Health. Illness forced his retirement in 1965 and he moved to Rochester, Minn. He was a member of the Marion County Medical Society.

Ireneo Bringas, M.D.

Dr. Ireneo Bringas, former Gary physician and member of ISMA, died April 14 in Big Spring, Texas, at the age of 61.

Dr. Bringas, who was a staff physician at U.S. Steel Corporation, Methodist and Mercy Hospitals there, moved to Big Spring four years ago.

Richard R. Gutstein, M.D.

Dr. Richard R. Gutstein, 81-year-old Kendallville general practitioner, died April 3 in Fort Wayne after a short illness.

Born in Poland, Dr. Gutstein was graduated from the University of Berlin Medical School in 1913. He came to Kendallville in 1923, setting up practice. He was a Senior Member of ISMA, a member of the 50-Year Club and the Noble County Medical Society.

Orville G. Hamilton, M.D.

Dr. Orville G. Hamilton, Bluffton physician for 45 years, died April 18 at the age of 75.

Graduated from the I.U. School of Medicine in 1922, Dr. Hamilton began practicing in Bluffton in 1922. He was associated in small medical centers with other physicians, the latest Dr. Constantine Panos. Dr. Hamilton was a member of the Wells County Medical Society and a Senior Member of ISMA.

E. W. Lehman, M.D.

Dr. Emery W. Lehman, retired physician whose medical and surgical career included service in World Wars I and II, died May 23 at the age of 78.

Dr. Lehman was graduated from the Chicago College of Medicine and Surgery in 1915, practiced in Iowa for many years and went to Bluffton in 1953, when he retired from active practice. He was a member of the Wells County Medical Society and the ISMA 50-Year Club.

Frank J. McMichael, M.D.

Dr. Frank J. McMichael, 82, one of Gary's first medical doctors, died May 15 at Gary's Methodist Hospital.

Dr. McMichael practiced medicine in Gary from 1908 to 1954, when he moved to Hernando, Fla. following his retirement. He was graduated from the University of Michigan in 1907 and served for many years as chief of staff of Gary Mercy Hospital. He was a member of the Lake County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

George B. McNabb, M.D.

Dr. George B. McNabb, 75, Rush County's oldest practicing physician and a Lawrence County native, died April 22 at his home in Carthage.

A resident of Carthage since 1920, Dr. McNabb was graduated from the I.U. School of Medicine in 1919. He was a veteran of World War I, past-president of the Rush County Medical Society and a Senior Member of ISMA.

Alfred Mathys, M.D.

Dr. Alfred Mathys, Mauckport physician for 50 years, died April 29 at Louisville, Ky. He was 86 years old.

A native of Switzerland, Dr. Mathys came to the United States in 1883. He was graduated from the University of Louisville Medical School in 1909 and went to Mauckport after his internship. He also operated a drugstore and at one time served as Heth Township trustee in Harrison County. He retired in 1959. Dr. Mathys was a Senior Member of ISMA, a member of the 50-Year Club and the Harrison-Crawford County Medical Society.

E. C. Murphy, M.D.

Dr. Eugene C. Murphy, 59, radiologist for the South Bend Clinic, died May 2 in a Seattle, Wash., hospital while visiting a daughter there.

Graduated from the University of Alberta School of Medicine in 1935, Dr. Murphy had been the clinic's radiologist since 1939. He was a member of the St. Joseph County Medical Society.

Fred L. Pettijohn, M.D.

Dr. Fred L. Pettijohn, 93, Indianapolis general practitioner for more than 65 years, died April 26 at Winona Hospital.

Graduated from the old Indiana University Medical College in 1896, Dr. Pettijohn served four years as physician and surgical assistant at Central State Hospital. He was a charter member of the staff of St. Vincent's Hospital and also

served on the staff at Winona Hospital. He was also a member of the Marion County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

Perrie Q. Row, M.D.

Dr. Perrie Q. Row, physician in Hammond for more than 30 years, died April 1 in a nursing home in Dolton, Ill. at the age of 70.

Dr. Row retired from active practice in 1963. He began his medical practice in Hammond in 1927 and was an honorary member of the staff of St. Margaret Hospital. Born at Osgood, Dr. Row was graduated from the I.U. School of Medicine in 1924. He was a past president of the Lake County Medical Society, a Fellow of the American College of Surgeons and an ISMA delegate.

Richard R. Slough, M.D.

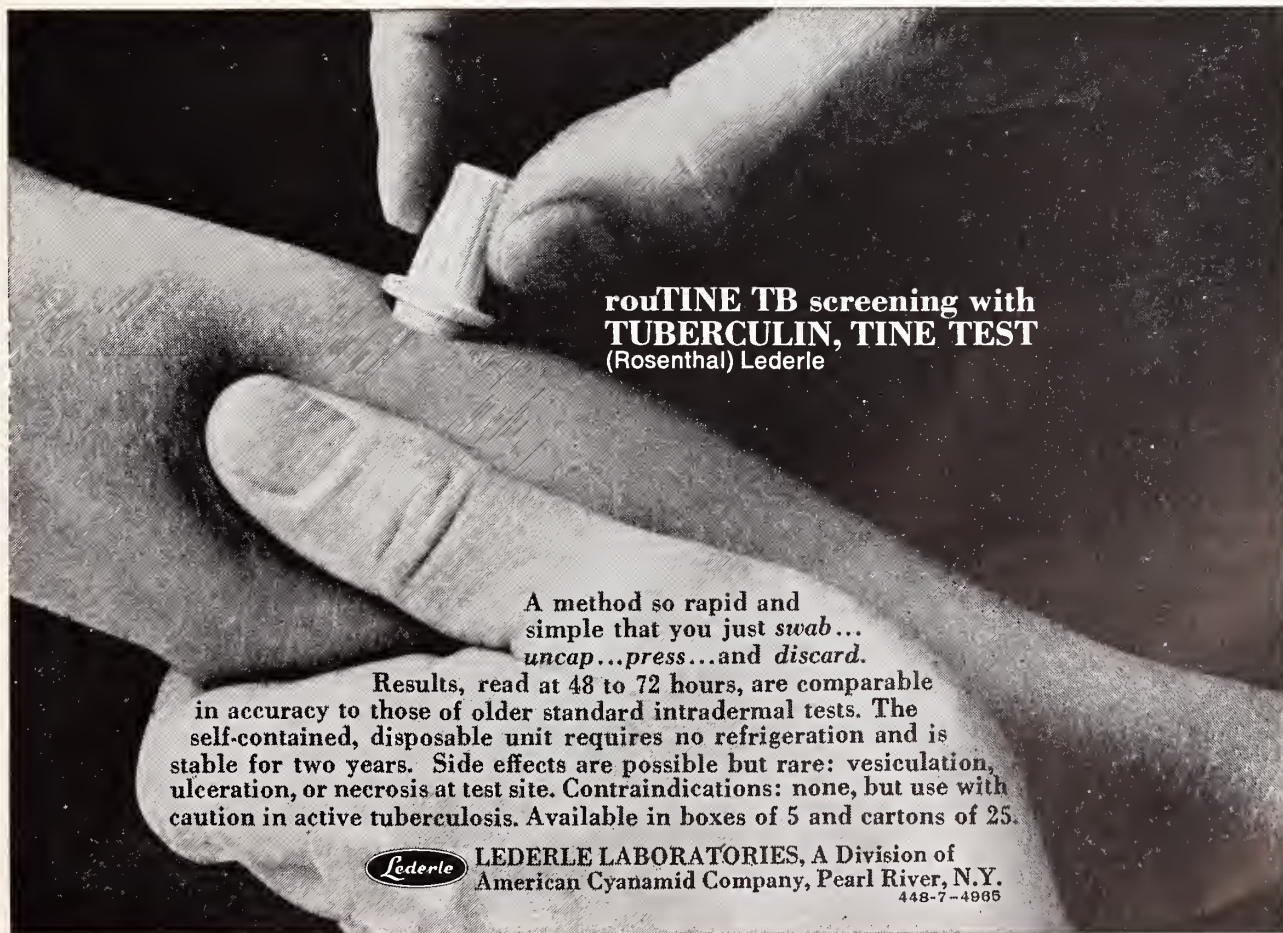
Dr. Richard R. Slough, 33-year-old Kendallville physician, died April 30.

Dr. Slough, who had practiced at Kendallville for nearly four years, was graduated from the I.U. School of Medicine in 1962. He was Noble County health officer, president of the medical staff at McCray Hospital and a member of the Noble County Medical Society.

Guy Wilson, M.D.

Dr. Guy Wilson, practicing physician in Bicknell since 1917, died May 9 at the age of 77.


Graduated from St. Louis University School of Medicine in 1916, Dr. Wilson was Bicknell city health officer for 25 years and was a member of the Knox County Medical Society. He was made a member of the ISMA 50-Year Club in 1966. ◀



**rouTINE TB screening with
TUBERCULIN, TINE TEST**
(Rosenthal) Lederle

A method so rapid and
simple that you just *swab...
uncap...press...and discard.*

Results, read at 48 to 72 hours, are comparable
in accuracy to those of older standard intradermal tests. The
self-contained, disposable unit requires no refrigeration and is
stable for two years. Side effects are possible but rare: vesiculation,
ulceration, or necrosis at test site. Contraindications: none, but use with
caution in active tuberculosis. Available in boxes of 5 and cartons of 25.

 **LEDERLE LABORATORIES**, A Division of
American Cyanamid Company, Pearl River, N.Y.
448-7-4965

Association News

EXECUTIVE COMMITTEE

April 8, 1967

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D.; G. O. Larson, M.D.; Lowell H. Steen, M.D.; Lester H. Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Robinson, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of	
December 31, 1966	4,409
1967 members as of March 31, 1967:	
Full dues paying	3,670
Residents and interns	90
Council remitted	45
Senior	305
Honorary	3
Military	4
Total 1967 members as of	
March 31, 1967	4,153
Number of members as of	
March 31, 1966	4,201
Lost over last year	48
Number of AMA members as of	
March 31, 1967	4,024
Total 1966 AMA members as of	
March 31, 1966	4,097
Loss over last year	73
1967 AMA members:	
Dues paying	3,517
Exempt, but active	507
	4,024
Number who have paid state	
dues but not AMA dues as of	
March 31, 1967	129

Treasurer's Office

In the absence of the treasurer, the treasurer's report was given by the assistant treasurer and the report was accepted on motion of Drs. Hoyt and Larson.

Legislation

National: The secretary reported on SB-1366, the handling of drugs under Title XIX, and the proposed social security amendments covered in HR 5710, and his report was accepted for information.

Local: The committee discussed the naming of the representative provided for in SB-359, recently adopted by the Indiana General Assembly and known as "The Indiana Plan" and it was taken by consent to present three names to the Governor from the Indiana State Medical Association for membership on this advisory board.

A letter from Mr. John Payne, thanking the association for its support of the hearing aid and licensure bill, was read for the information of the committee.

Organization Matters

The secretary gave a report on his con-

ference with representatives of the Continental Casualty Company concerning the ISMA disability program and submitted a letter from J. Russell Townsend, broker, asking permission to personally visit physicians who had been turned down for the regular policy. The solicitation of these members by the Continental Casualty Company was approved on motion of Drs. Larson and Kintner.

The AMA disability program was reviewed and report made that this will be made a special order of business at the AMA House of Delegates meeting in June.

The secretary reported on a letter received from the Vanderburgh County Medical Society concerning the difficulty in handling Kentucky welfare patients in Vanderburgh County and reported that he had suggested to the secretary of the Vanderburgh Medical Society that this matter be discussed with the welfare officials of Kentucky and the Kentucky State Medical Association. This was approved by consent.

The secretary read a letter from a member, and a copy of his reply, concerning a problem that the physician is having as a member of a hospital staff, and on motion of Dr. Rifner, taken by consent, this matter was referred to the Council.

The secretary read a report of the AMA Judicial Council on drug ownership, which was taken as a matter of information.

The secretary referred to the committee a report from one of the field staff concerning a development in a county of his district, and upon motion of Dr. Larson, taken by consent, this matter is to be referred to the Council with the recommendation that the president be authorized to appoint an ad hoc committee to deal with the subject of areawide planning.

For the information of the committee the secretary read a notice of a public hearing for rezoning of a property on North Pennsylvania Street adjoining that owned by the association, for business purposes.

Various correspondence regarding the Blue Shield contract was reviewed and discussed by the attorney. Upon motion of Drs. Larson and Kintner, it was agreed that the old Section D in the original proposal by the association should be included in the contract between Blue Shield and the Department of Public Welfare.

Upon motion of Drs. Larson and Hoyt, the same Section D is to be incorporated in the contract between Blue Shield and the Indiana State Medical Association.

A resolution submitted by the Howard County Medical Society was referred to the Council by consent.

Annual Convention, Indianapolis, October 9, 10, 11 and 12, 1967

The annual convention, to be held in Indianapolis, was discussed and upon motion made and taken by consent, it was recommended that the Executive Committee of the association meet on Sunday evening, that the Council meet for a breakfast meeting at 7:30 Monday morning and that the first meeting of the House of Delegates be held at 2:00 p.m. on Monday.

New Business

The chairman brought up the matter of the Marion County Medical Society being desirous of selling its existing property at 2902 North Meridian Street and working out a program of either leasing or purchasing a part of the association property located on North Pennsylvania Street. By consent this matter is to be referred to the Council.

A report was made that six district meetings had been scheduled for the same day during the month of May. By consent it was agreed to call this to the attention of the Council and recommend that the Council take steps to establish district meeting dates so as to avoid this problem.

Upon motion of Drs. Steen and Larson it was voted to inform the Council that the Executive Committee would favor any recommendation made by the Council concerning emergency medical services and a survey of same.

Journal

The suggestion of the State Journal Advertising Bureau for distribution of a limited number of journals to detailmen of the various drug companies was discussed by Dr. Ramsey, and upon motions of Drs. Larson and Steen, it was agreed that the association would go along with this proposal on a trial basis for a period of one year and at the end of the year the idea is to be evaluated.

Future Meetings

The invitation for a representative to attend The Better Business Bureau meeting on April 24, 1967, was reviewed, and no representative will be sent to this meeting.

Regional Conference of Medical Society Executives, Columbus, Ohio, May 2 and 3, 1967. By consent it was agreed that the field staff could be sent to this meeting.

There being no further business the committee adjourned, to meet again at 4:00 p.m., Saturday, June 10, 1967. ◀

THE COUNCIL

April 9, 1967

The Council of the Indiana State Medical Association convened for its spring meeting at 8:00 a.m., Sunday, April 9, 1967, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:

Councilors:

- First District — P. J. V. Corcoran, Evansville
- Second District — Joe Dukes, Dugger
- Third District — Donald M. Kerr, Bedford
- E. L. Wallace, New Albany, alternate
- Fourth District — Robert M. Reid, Columbus
- Jack E. Shields, Brownstown, alternate (also AMA delegate)
- Fifth District — Not represented
- Sixth District — William R. Tindall, Shelbyville
- Frank H. Green, Rushville, alternate (also AMA delegate)
- Seventh District — Albert M. Donato, Indianapolis
- Eighth District — Donald R. Taylor, Muncie
- Ninth District — Peter R. Petrich, Attica
- Tenth District — Lowell H. Steen, Whiting
- Herman Wing, Gary, alternate
- Eleventh District — Lowell J. Hillis, Logansport
- James A. Harshman, Kokomo, alternate
- Twelfth District — Milton F. Popp, Fort Wayne
- William R. Clark, Fort Wayne, alternate
- Thirteenth District — Otis R. Bowen, Bremen

Officers:

- Eugene S. Rifner, Van Buren, president
- G. O. Larson, LaPorte, president-elect
- Ottis N. Olvey, Indianapolis, treasurer
- Lester H. Hoyt, Indianapolis, assistant treasurer

Journal:

- Frank B. Ramsey, Indianapolis, editor

Executive Committee:

- Ralph V. Everly, Indianapolis, chairman
- Burton E. Kintner, Elkhart, member

Guests:

- Harold C. Ochsner, Indianapolis, AMA delegate
- Guy A. Owsley, Hartford City, AMA delegate
- James H. Gosman, Indianapolis, AMA alternate delegate
- Robert M. Brown, Marion, AMA alternate delegate

- Kenneth O. Neumann, Lafayette, AMA alternate delegate
- George T. Lukemeyer, Department of Medicine, I. U. School of Medicine
- A. C. Offutt, Indianapolis, State Health Commissioner
- Lester D. Bibler, Indianapolis, AMA trustee, and chairman, Student Loan Committee
- Glen V. Ryan, Indianapolis, chairman, Blue Shield Board
- Richard B. Hovda, Evansville, chairman, Commission on Convention Arrangements
- Victor M. Brian, Vice President—Operations, Blue Shield

Staff:

- Robert Robinson, attorney
- Ralph Hamill, attorney
- Robert J. Amick, field secretary
- Howard Grindstaff, field secretary
- Kenneth W. Bush, administrative assistant
- James A. Waggener, executive secretary

On motion of Drs. Taylor and Petrich, minutes of the meeting held January 22, 1967, were approved as printed in the March, 1967, Journal.

Reports of Councilors

The councilors announced the dates and places of their respective district meetings. (Listed on page 891 in The Journal.)

Reports of Officers

DR. EUGENE S. RIFNER, President: Mr. Chairman, there is not a whole lot for me to report. I have been traveling, as I have been asked to, nearly every week. The reports of the legislature will be given to you later. I did attend a Blue Shield meeting in Hot Springs at the expense of Blue Shield where I was rather heartened to find out that most of the national Blue Shield people realized from whence they

came. It was enlightening not only to Jim and to me, but I am quite sure it was to Mr. Kilborn.

I would like to have you note that there are several district meetings on May 17, and on the 17th of May I shall be attending a state meeting in Ohio, so this gets me off the hook. I won't have to choose which of these districts I attend. I would try to impress upon the councilors that there are elections at these meetings. The next President's Page will request that the membership try to turn out in force for their district meetings, because several of you have served two terms and I have requested that they return men of the same or better caliber. It is not meant to be a slam to those who are leaving, but I think never before have we needed the best caliber men we can have. The same districts will be electing men to the Blue Shield Board. I think all of us here, from our trials of last year and this year with Blue Shield, and our understanding of them, realize the necessity for picking men who are willing to work, who are willing to ferret out and coordinate the problems of Blue Shield with the policies of the Indiana State Medical Association and still keep the membership of Blue Shield in mind as it is done. We don't need any more knife and fork members on that board. We need people who are active, energetic, and perhaps somewhat obstinate.

I have nothing further to offer at this time so we'll turn it back to the chairman.

DR. G. O. LARSON, president-elect: Mr. Chairman, I have nothing to add to what the president has already said.

DR. LESTER H. HOYT, assistant treasurer, presented the following report on the financial status of the association as of March 31, 1967:

SUMMARY OF ALL FUNDS

	Cash	Investments	Total
General Fund	\$47,098.85	\$273,259.19	\$320,358.04
Journal Fund	2,748.74	—	2,748.74
Medical Defense Fund	3,288.59	35,000.00	38,288.59
Building Fund	8,388.46	—	8,388.46
Building Fund — Auxiliary donation	—	3,777.71	3,777.71
Student Loan Fund (old)	232.25	12,922.33	13,154.58
Kitchen Fund	—	1,771.79	1,771.79
	\$61,756.89	\$326,731.02	\$388,487.91

On motion of Dr. Hoyt, duly seconded, the report of the assistant treasurer was adopted.

DR. FRANK B. RAMSEY, editor of *The Journal*: Mr. Chairman, and members of the Council: The advertising market is good this year. Last year the national agency had an increase of about 45% in its total business for that year over the previous year, and this year they are running 56% ahead of last year. Our own journal is 41% ahead of last year. This helps account for the excess of revenue over expense at the present time of \$6,500.00, which, I might say, is not way out of line because the Roster issue in June and the convention issue in September are the two big issues and require considerably more money for printing than ordinary issues.

Report of AMA delegates. The AMA delegates reported that they had received many letters regarding the AMA disability insurance program and that this matter will be a special order of business at the AMA House of Delegates meeting in June.

DR. LESTER D. BIBLER, AMA Trustee, reported on items discussed by the Board of Trustees of the AMA at its last meeting, as follows:

(1) Resolution No. 77, introduced in 1954 by the ophthalmologists, and resolution presented in 1966 reaffirming the feeling of the ophthalmologists toward optometrists. This action has been adjudged as conspiracy against optometrists and it may result in a suit in the sum of \$90,000,000.00. If the matter comes to trial, it will cost the AMA approximately \$100,000.00. (Has been settled out of court).

(2) Representation of lay organizations on the Joint Commission on Accreditation of Hospitals.

(3) Disability insurance program. In a special meeting on this subject, the Board of Trustees voted to accept the recommendations of the Committee on Insurance and Prepayment Plans authorizing a decrease in benefits, an increase in premiums, cancellation of all policies at age 70, and requiring annual reports from age 60 to 70.

In view of letters received from state medical societies of Indiana, California, Illinois and Texas, and many individual physicians, requesting that this matter be resolved by the AMA House of Delegates, the above action was rescinded, and the matter will be referred to a special reference committee, for discussion and decision, at the AMA meeting at Atlantic City in June.

Matters Referred to Council By Executive Committee

1. *Suit against Blue Cross.* Judge Hamill reported that the suit had been filed.

2. *Council meetings.* The recommendation of the Executive Committee that the Council meet every other month in order more adequately to handle the matters which are coming before the association was discussed by Drs. Kerr, Corcoran, Donato, Taylor, Popp, Rifner, Neumann, Harshman, Reid, Larson, Petrich and Dukes.

Dr. Kerr moved that the Council submit to the House of Delegates a resolution that the Bylaws be changed to concur with the recommendation of the Executive Committee that the Council meet every two months starting January of each year, in addition to those meetings associated with the annual convention, plus such other meetings as may be called by the chairman of the Council and as provided by the Constitution and Bylaws as it presently stands. Motion seconded by Dr. Hillis, and discussed by Drs. Petrich and Larson.

Drs. Petrich and Reid moved to amend the above motion to alter the monthly rotation which would make the meetings fall in February, April, June, August, October and December. Motion discussed by Drs. Clark, Petrich, Taylor, Popp and Bowen, the feeling being that specific months for meetings should not be mentioned but that additional meetings should be held as are warranted, to accomplish the duties of the Council.

On voting, the motion to amend Dr. Kerr's motion which would schedule meetings every other month starting with February was lost unanimously.

On voting, Dr. Kerr's motion that the Council meet every two months starting in January of each year was lost unanimously.

On motion of Drs. Kerr and Hillis the Council then voted to follow the Constitution and Bylaws as presently written, giving the chairman of the Council the authority to call special meetings of the Council as needed. (Chapter VII, Section I).

On motion of Dr. Corcoran, seconded by many, the Council voted to refer to the Commission on Constitution and Bylaws consideration of changing the provision in Chapter VII, Section 1, of the Bylaws which now stipulates that the Council shall meet in January, April and July of each year, in order to work out a suitable substitute to provide flexibility as may be required.

3. *Relationship of a physician to hospital staff.* Correspondence in this matter was read by Dr. Everly. By consent, the Council directed the executive secretary, or the president, to write to the physician con-

cerned and tell him that in accordance with Chapter VII, Section 2, of the Bylaws ("Each councilor shall be organizer, peace-maker, and censor for his district"), he should discuss this matter with his councilor.

4. *Areawide Planning.* Dr. Everly reported that attention of the Executive Committee had been called to the activity of the Indiana Hospital Association in a meeting with the staff of the Henry County Hospital in urging them to make use of the Indiana Hospital Association facilities and staff for the purpose of developing an areawide planning program in their area.

"We note that the hospital staff finally concurred in recommending to the board of trustees of that hospital that they meet jointly with the hospital association in establishing such a program. You will recall that at the inception of this idea some two or three years ago, when the matter of cooperating with the hospital association in this effort was discussed, the action of the Council was that we would support areawide planning, to be done through the office of the State Board of Health rather than through the hospital association. Now it is apparent that areawide planning is going to be a definite part of the programs of today and tomorrow under federal regulations. The Executive Committee therefore feels that the association must become active in this particular effort and recommends that the Council authorize the president to appoint an Ad Hoc Committee who will be charged with the responsibility of studying and making the association effective in areawide planning situations. The Executive Committee will heartily favor any recommendations made by the Council on emergency medical services."

Dr. Kerr moved that the Council refer this matter to the Council Committee for the Study and Implementation of Governmental Medical Programs. Motion seconded by Dr. Petrich. Discussed by Drs. Popp, Gosman, Neumann, Kerr, Corcoran and Hillis. Dr. Kerr expressed the hope that the Council committee specified would make efforts to confer with Dr. Offutt on this matter without delay.

On motion of Drs. Taylor and Kerr, the Council approved amendment of the above motion to include "that the Council Committee on Governmental Programs report in detail on this subject at the next Council meeting."

On voting, the motion to refer the matter of areawide planning to the Council Committee for the Study and Implementation of Governmental Medical Programs was adopted.

5. *Resolution from Howard County Medical Society.* Dr. Everly read the following

solution, which was adopted on April 4, 1967, by the Howard County Medical Society:

"SUBJECT: Manner of Payment to Physicians for Welfare Cases.

"WHEREAS, the present arrangement for payment of physicians for welfare cases allows Blue Shield to set fees for physician efforts, leaving the responsibility of objecting up to the physician, and

"WHEREAS, this is extremely odious to the practicing physician of ISMA and is contrary to the American way of life,

"BE IT RESOLVED, that the present arrangement be abandoned and that instead, a system be devised whereby the physician has the right to set his fee and the insurance company has the right to object; and further, that this objection be made to a committee of representatives of the insurance company and a board of censors of the local medical society; that committee consisting of an equal number of insurance representatives for the number of local board censors.

"BE IT FURTHER RESOLVED, that the Council of the ISMA accept nothing less than this Resolution in their agreement with Blue Shield, with any other official welfare carrier, or with the Indiana Welfare Department, itself, for physician payment in welfare cases.

"BE IT FURTHER RESOLVED, that this Resolution when passed, be presented to the next AMA convention by the Indiana delegation."

Discussed by Drs. Popp, Rifner, Taylor and Harshman.

Dr. Kerr moved that the resolution be referred to the ISMA House of Delegates. Motion seconded by Dr. Hillis, put to vote, and carried.

6. Amendment to Bylaws on Compulsory Payment of AMA Dues. Dr. Everly read the following letter, addressed to the Executive Committee by the Marion County Medical Society:

"At the behest of the Board of Directors of this Society, I am writing to request that the Executive Committee direct the Commission on Constitution and Bylaws of the Indiana State Medical Association to prepare an amendment to require that members of the State Medical Association be members of the American Medical Association.

"In its recent meeting, the Board voted to direct the Society's Committee

on Articles and Bylaws to take similar action in regard to Society membership. Our Bylaws now require that this office collect the dues of all three organizations and the Board consistently has interpreted that requirement to mean that members must pay all three. Our proposed amendment would tie the requirement to membership provisions instead of to dues collections.

"It is the Board's belief that the action by the State Association is the proper way to insure the medical profession's support of its national organization."

On motion duly made, seconded, put to vote, and carried, the above letter was tabled.

7. District meetings. Dr. Everly called attention to the fact that six district meetings have been scheduled on May 17, 1967, and the Executive Committee recommended that the Council consider a means whereby these meetings may be arranged without conflicts in the various districts. "We understand that the Future Planning Committee is going to meet with the councilors, the Executive Committee and the officers of the district societies on April 30. We feel this is an important meeting and that we should be present in participating to devise a plan to make our district meetings more effective."

8. Permanent home for Marion County Medical Society. Dr. Everly reported that the Executive Committee had been approached about leasing or renting some of the ISMA property to the Marion County Medical Society for an office. Following discussion by Dr. Donato and Gosman, **on motion of Drs. Taylor and Kerr, the Council referred this matter to the Council Committee on Economics and Fiscal Matters with the request that that committee meet with the appropriate persons in the Marion County Society and the state association, and report back at the next Council meeting.**

Economic and Organization Matters

1. Remission of state dues.

a. The chair ruled that due to the absence of the councilor and since the Council must be informed as to whether or not financial hardship exists, no action could be taken on the request for remission of state dues of a member in the Fifth District who has discontinued practice because of ill health.

b. On motion of Drs. Donato and Popp, remission of state dues of a member of the Seventh District who

has had to quit practice because of ill health was approved.

c. On motion of Drs. Popp and Donato, remission of state dues of a member of the Twelfth District because of age, retirement and consequent financial hardship was approved.

d. Dr. Petrich presented a request from a county society in the Ninth District for remission of state dues of a member who has been forced to retire long before he had planned to because of blindness and resulting financial hardship. **On motion of Drs. Petrich, Kerr and Taylor, permission was granted to remit this member's dues.**

2. Ad Hoc Committee to Study Regulations on Remission of Dues, and Other Membership Matters. Following the suggestion of Dr. Bowen and discussion by Drs. Kintner, Taylor, Popp, Dukes, Petrich and Gosman, the chairman appointed Dr. Bowen chairman of the committee to study membership matters, including the remission of dues. Dr. Bowen is to select three other councilors to serve with him and the committee is to report to the Council at its next meeting.

3. Nomination of two members for Editorial Board, for three-year term ending December 31, 1970.

Dr. Jene R. Bennett, South Bend (pathology) was nominated at the January 22, 1967, Council meeting, to succeed himself for the three-year term ending December 31, 1970.

Dr. Corcoran nominated Dr. W. D. Snively, Jr., Evansville (pediatrics and administrative medicine), to succeed Dr. Harold D. Lynch, Evansville (pediatrics), for the three-year term ending December 31, 1970.

4. Blue Shield Board of Directors. Dr. Steen called the attention of the Council to the fact that Districts 1, 5, 8, 9 and 12 should nominate this year one member each for the Blue Shield Board of Directors, for the three-year term beginning March, 1968, and ending March, 1971.

Blue Shield member-at-large. The term of one member-at-large, Dr. Earl W. Mericle, Indianapolis, will expire March, 1968.

On motion of Drs. Donato and Popp, Dr. Mericle was nominated to succeed himself for the three-year term from March, 1968, to March, 1971.

5. Reports of Commissions and Committees.

a. **Commission on Convention Arrangements.** Dr. Richard B. Hovda, chairman, reported as follows:

(1) There has been considerable activity suggesting that the trap and skeet

shoot be reinstated and a chairman has been appointed for this event, pending approval of the Council, and the chairman has asked for a budget of \$50 to \$75.

(2) Some nationally known figures on cancer have been asked to present a program on the current status of various cancer treatment methods on Wednesday afternoon, following the section meetings. These speakers may be available for presentations before the sections at noon luncheons.

(3) Dean Irwin has agreed to get a group of at least four departments of I. U. School of Medicine to present their current developments of particular interest. He would like to do this at a different time than is usual, perhaps at a cocktail hour, or in some similar informal setting, possibly in four separate rooms, simultaneously, and he has suggested the new Stouffer Inn. "He thought that the Wednesday period of the scientific session, before the President's night and entertainment, might be a time at which we could get a good sized attendance. . . . This seems like an innovation that is worthwhile considering."

On motion of Drs. Corcoran and Kerr, the Council approved the recommendations of the Commission on Convention Arrangements for the 1967 annual convention.

Business Meetings. By consent, the Council approved the following schedule for the business meetings during the convention:

Sunday evening, October 8, 1967 — Executive Committee meeting; Monday, October 9, 1967, 7:30 a.m.—Council breakfast meeting; Monday, October 9, 1967, 2:00 p.m. — Meeting of House of Delegates; Thursday, October 12, 1967 — Final meeting of House of Delegates, followed by meetings of Council and Executive Committee.

b. *Committee on Student Loan.* Dr. Lester D. Bibler, chairman, reported briefly on student loan matters.

The committee met on January 22, 1967, and granted a loan of \$300.00. To date 66 loans, totaling \$54,900.00, have been made under the Guaranteed Loan Plan through the Indiana National Bank.

Under the old student loan program, of the \$58,450.00 loaned to 117 students, \$10,985.00 is still outstanding, and the committee is making every effort to collect all accounts now due.

Dr. Bibler asked authorization of the Council to take more positive action on some of the delinquent accounts.

By consent the report of the committee was accepted for information.

c. *Voluntary Health Agencies.* Discus-

sion of the mailing of the poster on voluntary health agencies to all members of the association brought out the following points:

(1) The Executive Committee had recommended that this be done, based upon recommendation from one of the commissions.

(2) At its meeting on January 22, 1967, the Council took no adverse action to the report presented by the Commission on Voluntary Health Agencies, in which it was recommended that the placard be sent to each member of the association. Also, a legal interpretation on endorsing or not endorsing the various organizations was obtained from Mr. Hollowell.

The chairman announced that unless the Council passed a motion to the contrary the mailing of this and similar material would be continued under the implied consent of the Council at its January, 1967, meeting.

Following discussion by Drs. Taylor, Corcoran, Popp and Gosman, **motion was made by Dr. Taylor, seconded by Dr. Dukes, that any further mailings of documents of this nature be suspended until such time as the matter is studied further and clarified. Motion put to a hand vote, and lost.**

d. *Measles immunization program.* Dr. Kerr asked for an expression of the Council regarding mass immunization programs, with special reference to the measles eradication program.

The chairman reviewed the action taken by the Council at its January 22, 1967, meeting, at which time the plan for eradication of measles from Indiana in 1967, as outlined by Dr. Offutt, was approved. (Page 377, March, 1967, *Journal*).

e. *Commission on Public Health.* The chairman read the following report, written by Dr. Thomas O. Middleton, chairman of the Commission on Public Health:

The Commission on Public Health is concentrating its efforts in the fields of environmental sanitation and in specific disease control. As far as the first effort is concerned, members of this commission have been active in establishing water quality standards, appearing at various regional hearings throughout the state of Indiana as well as the statewide meetings in Indianapolis. The matter of sanitation and public health problems at developing resort areas has been assigned to various committee members. Throughout the next few months this will be given major interest with efforts directed to coordination with county medical societies in the area of these newly developed recreational projects to the end that such areas will be of much greater value to citizens in the state and much less a hazard to their health. Ex-

isting areas of pollution both of the water resources — which is statewide — and air pollution — which is limited primarily to large communities and certain industrial complexes — is undergoing study, and members of the commission are cooperating with state and federal agencies and interested citizens groups concerned with abating, if not completely removing, those factors which are a menace to the health of the people.

In regard to the second main effort, the commission has conferred with interested voluntary agencies and the State Board of Health on a broad immunization program for measles. A pilot program has been set up in one county which will serve as a guide to similar programs now being considered for other places throughout the state. It should be noted that in many areas private physicians have vigorously pushed the use of measles vaccine so that large numbers of pre-school children have already been immunized. It is generally agreed that immunization should be given to those children under the age of 12 who have neither had measles (rubeola) or measles vaccine, and that the emphasis of any program should be on immunizing the pre-school child. Vaccine is available through the State Board of Health for individual as well as community use. It is anticipated that practically all of the current supply will be used in community projects.

Junior-Senior Day was held on April 1 at the Holiday Inn (Airport). The afternoon session was well attended, and it was the opinion of observers that there were more students and wives in attendance than at previous meetings. The total registration including the dinner was two hundred. Expenses again were shared by the Indiana State Medical Association, Blue Cross-Blue Shield and Mead Johnson. A questionnaire was distributed to each participant and a general response to a question as to the effectiveness of Junior-Senior Day was as follows: The students expressed appreciation for the affair. Plans are being made to further evaluate other questions which dealt with internships and residency programs in Indiana. The report on this evaluation will be made to the Council at its next meeting.

Special commendation should be given to Dr. Neal Petry, Delphi, for his excellent work in arranging panelists, speakers and conducting the meeting, although it would be impossible to put on such an affair without the wholehearted assistance of the Indiana State Medical Association office staff.

It is my opinion, shared by Dr. Petry, that the emphasis of Junior-Senior Day on

interesting individuals in general practice in rural areas needs to be re-evaluated. The JCP Club, sponsored by the Indiana Academy of General Practice, and more specifically the Marion County chapter, provides several programs during the year which to a considerable extent duplicate the effort of the Indiana State Medical Association. With current emphasis on retention of physicians of all categories for practice in the communities of this state, it would seem that we should plan a program which would be of more general interest to juniors and seniors and emphasize the advantages of practice of any variety in this state. If it is the consensus of the Council that the emphasis needs re-orientation, the commission will develop a specific program for consideration.

It is requested that two members of the commission represent the Indiana State Medical Association at the 10th National Conference of Schools and Physicians in Chicago in October, 1967.

On motion of Drs. Petrich and Taylor, the request that two members of the Commission on Public Health be sent to the Tenth National Conference of Schools and Physicians, to be held in Chicago in October, 1967, was referred to the Executive Committee for decision.

Dr. Petrich moved that the Commission on Public Health "develop its specific programs for re-orienting the emphasis on Junior-Senior Day, in line with its ideas as expressed in the report." Motion seconded by Drs. Bowen and Reid, put to vote, and carried.

f. DR. HERMAN WING, official representative of the Indiana State Medical Association to the *National Medicolegal Symposium, sponsored by the American Medical Association and the American Bar Association*, Miami Beach, Florida, March 9-11, 1967, reported briefly: "The AMA had a very fine meeting, in conjunction with the American Bar Association, and presented the third in a series of national symposia which, of course, was successful in fostering harmonious relationships between our colleagues in the legal profession as well as in our own. The program was very comprehensive and dealt with a number of controversial matters such as impartial medical testimony, expert witnesses testimony and their payments and fees, insanity as a defense to criminal liability, the physician's utilization of an attorney in his practice, and some other subjects.

"The meeting was attended by some 1,800 lawyers and physicians. Also, 50 representatives of county and state medicolegal committees were present, and a joint meet-

ing was held for the first time, sponsored by the AMA Committee on Medicolegal Problems. Here we found free-flowing discussion concerning the problems that dealt with local panels for malpractice cases, and developing of codes of professional relations between lawyers of physicians at the local level. It is planned to have a more formal program for this group at the next symposium, which will be held in 1969.

"It was a pleasure to represent the Indiana State Medical Association at these meetings."

Reports of Guests

DR. GEORGE T. LUKEMEYER, I. U. School of Medicine, representing Dr. Glenn W. Irwin, Jr., Dean: Dr. Irwin is sorry that he could not be here. He is attending the American College of Physicians' meeting in San Francisco.

The school has been extremely pleased and gratified with the cooperation we have had with your officers and your hard-working staff during the last several months. Other than this, I have nothing further or specific to report but I would attempt to answer any questions you might have. Where I do not have answers I would be more than willing to attempt to obtain the information for you.

In answer to questions, and for the information of the Council, Dr. Lukemeyer discussed (1) teletype service offered by the University; (2) library services; (3) one-day preceptorships for freshmen medical students, and (4) preceptorships for senior medical students, an elective in the Department of Medicine.

Payment of fees for welfare recipients under Part B of Title XVIII, PL 89-97. The chairman called attention to the action taken by the Council at its January 22, 1967, meeting regarding collection of fees for care of over-65 welfare patients, at which time two alternatives were agreed upon:

Alternative No. 1. The physician forwards his bill to Blue Shield on form 1490 on each patient, along with a statement on his letterhead indicating that he will accept Blue Shield's determination of what is a usual and reasonable fee for the services rendered. In the event the physician feels the allowed fee is unreasonable, he has the right to refuse payment and request a hearing by Blue Shield.

Alternative No. 2. The physician files an itemized statement with Blue Shield who determines whether or not the fee is reasonable, and Blue Shield sends the physician one check. The physician, in turn, must supply Blue Shield within ten days an itemized statement marked, "Paid in Full."

THE CHAIRMAN: Now this was the

area in which we did not think there would be great utilization. We then received a letter from Blue Shield indicating they needed on file a contractual type agreement from physicians, and this has gotten us into some difficulty with certain members . . . The Council was not informed of this, yet the question had been raised by Dr. Rifner several times at the Blue Shield Board meeting. We felt that Dr. Ryan should come and explain Blue Shield's position with regard to this. Dr. Ryan, please!

DR. GLEN V. RYAN, chairman, Board of Directors, Mutual Medical Insurance, Inc. of Indiana, explained that the contractual agreement was proposed between Blue Shield and those individuals who elected to use the second alternative, in order to protect Blue Shield. "Blue Shield cannot be reimbursed by Social Security or the State Welfare Department unless we have an itemized statement marked, 'Paid in Full.' We have to run Blue Shield on a businesslike basis. We cannot send a physician a check and depend upon his word that he is going to send us a receipt, 'Paid in Full.' If we don't get that receipt we may have lost some of our members' money, and I am sure that the members of Blue Shield and the state insurance commissioner would not like that very well and we would be in trouble."

Dr. Popp asked if the recipient's endorsement of the check would be accepted as a receipt. This was discussed by Drs. Ryan, Popp, Kerr, Wing, Green and Mr. Victor M. Brian, Vice-president of Operations, Blue Shield.

MR. VICTOR M. BRIAN: I believe this question has been brought to us before, and I believe Mr. Waggener has also asked the Social Security Administration if this could be possible. At that time they gave us an answer that it was not acceptable. In the regular insurance business a canceled check will not serve as a paid receipt because it does not specify what it represents. There could be other charges there, and at the present time the canceled check would have to be tied back to the claim and it goes into another area. I believe those who talked with Social Security could also verify what we recommended originally, because it seemed a simple way. At that time Social Security said it could not be done.

Dr. Green asked the question, "Could not a number be assigned to a claim and that number be put on the check with the number corresponding to the claim number and that serve as a receipt, so it could be identified?" and Mr. Brian agreed to pursue this possibility.

Discussed further by Drs. Rifner, Green, Ryan and Wing, following which **the chair-**

man assigned this matter to the Council Liaison Committee with Blue Shield for study and report back to the Council at the next meeting with a solution.

Contract between Blue Shield and Indiana State Department of Public Welfare. Dr. Everly, chairman of the Executive Committee, reported that the Executive Committee had reviewed the proposed contract between Blue Shield and the Indiana State Department of Public Welfare, and it was the feeling of the committee that it is important that paragraph D separating physicians' charges and defining them under the customary and reasonable charge basis should be included in the contract. Also, in reviewing the proposed contract between the Blue Shield Plan and the Indiana State Medical Association concerning the method of adjudicating disputes on fees between Blue Shield and the physician, the Executive Committee feels that this same paragraph outlining the method of determining fees should be incorporated in this contract.

Dr. Ryan said the contract had been submitted to the Attorney General's office after the ISMA and Blue Shield legal counsel had studied it, and it was decided that Blue Shield legal counsel and ISMA legal counsel should rewrite it.

The Attorney General's office did not like the paragraph (paragraph D) in the original contract concerning the adjudication of fees, so a supplementary contract was written between Blue Shield and ISMA in which it was resolved that "Blue Shield agrees that any dispute between the physician and Blue Shield as a carrier under PL 89-97 shall be submitted to and determined by an adjudication committee of the county medical society of which such physician is a member. If any member to such dispute does not agree with the determination, he may appeal to the appropriate committee of the Indiana State Medical Association. Blue Shield further agrees that any party to such dispute may appeal in any manner provided by law." This is signed by the president of Blue Shield, Mr. Kilborn.

Paragraph D, as Blue Shield originally wrote it and recommended, reads as follows:

"Reasonable charges of physicians means the charges of physicians rendering services to welfare recipients 65 years of age or older, and shall be determined on the basis of the usual and customary charges for similar services generally made by the physician furnishing said services, taking into consideration the charges for like or similar services in the locality and provisions contained in PL 89-97."

MR. ROBERT ROBINSON, legal counsel: A woman attorney in the Attorney General's office who rewrote this contract reduced this to "reasonable charges for medical services, and reasonable costs of medical services means the reasonable charges or costs of such services as defined and included in PL 89-97." Now, this is completely different from what we intended . . . She brought in some of the costs for other services. However, we think paragraph D as now written is completely unacceptable. We have suggested a change in paragraph D as written by the Attorney General whereby first of all it would read this way:

"Reasonable charges for medical services and reasonable costs of medical services means the reasonable charges or costs as defined and included in PL 89-97."

In other words we dropped out "such services."

Then, in addition, we also strongly recommend that our original paragraph D be placed in the contract.

Mr. Robinson also stated he would recommend that an attempt be made to get this paragraph incorporated in the contract between Blue Shield and the State Department of Public Welfare.

On motion of Drs. Donato and Petrich, the Council voted "to follow the advice of the attorney and to pursue the issue to the greatest extent."

Dr. Wing asked two questions of the attorney: (1) Why did the Attorney General leave out the usual and customary charges in the recommended paragraph, and (2) Why is the term "reasonable costs" introduced?

MR. ROBINSON: As yet we have not gone to the Attorney General to find out. We wanted some affirmation here as to what we could do or what we couldn't do before we go and find out why they did what they did. Possibly she brought in these reasonable costs regarding hospital and other services which we did not, because this wasn't of concern to us, but she picked them up seeing that this was also there, and in so doing, she got them running together without knowing what she had done and I hope that this is it, because if this is it, I think by sitting down and explaining it, she will be more than willing to separate the two. . . . Of course this is very important to us that these two be completely disassociated.

Item No. 7. This relates to Item 7 of the contract, which has remained the same, through the Attorney General's office. Item 7, as it presently reads,

"It is further agreed that any disputes between the physician and the contract or

the department shall be submitted to and determined by a method permitted or authorized by PL 89-97. If any party to such dispute does not agree with the determination he may appeal in any manner authorized by law."

The Executive Committee some time ago authorized us to make whatever changes we could in this. After much legal study it was our opinion that this could possibly be illegal if we attempted to add to it what we would like to have in it. So we thought the best way to handle this would be another agreement between the Indiana State Medical Association and Blue Shield. We have that agreement, it has been signed by Blue Shield. . . . I will read the important parts:

"Blue Shield agrees that any dispute between the physician and Blue Shield as a carrier under PL 89-97 shall be submitted to and determined by an adjudication committee of the county medical society of which such physician is a member. If any party to such dispute does not agree with the determination, he or it may appeal to the appropriate committee of the Indiana State Medical Association."

In this respect we feel that the contract between Blue Shield and the Indiana State Medical Association is acceptable without attempting to have this in the contract between the state and Blue Shield.

On motion of Drs. Kerr and Bowen, the Council accepted the recommendation of the attorney regarding item 7 of PL 89-97.

DR. A. C. OFFUTT, State Health Commissioner, reported on the measles eradication program. Monroe, Parke, Huntington, Elkhart, St. Joseph, Knox, Tippecanoe, Lake, Greene, and Owen counties have endorsed the program and have started, or have completed, immunization of all eligibles in these counties.

"We have been paying for the present stock of vaccine out of federal money which would normally revert. I now suggest that a broadside be prepared and that we ask the state office to send it to all physicians and that the State Board of Health send it only to local health officers."

Areawide Planning. Dr. Steen informed Dr. Offutt that prior to his arrival the Council Committee on Implementation of Governmental Programs, headed by Dr. Donato, had been appointed to advise and work with him on the matter of areawide planning.

Dr. Hoyt asked the question, "Do you consider your purview on areawide planning to be limited to those areas which are requesting federal funds, or are you inter-

sted in all health facilities regardless of funding?"

DR. OFFUTT: Up until the passage of 39-749, it would have been limited to federal funding. Now we will consider all health planning. This is why we are getting into nurse training, because this is through a separate law. Ordinarily arrangements for federal funds for nurse training is done by and between the local people and the federal government.

Dr. Kerr asked for information relative to the law about entrance into schools — kindergarten, first graders, and TB tests. "Is there any suggestion about how this is going to be handled or how we can handle it where they must have a certificate signed by a doctor? Now, I could have set it up with the health office to do it with a nurse doing the testing, with all this signed by a doctor. What do we do about that?"

DR. OFFUTT: This is the second inquiry we have had about how to operate this and we haven't crystallized our plans yet. We hope though to be able to have the necessary forms and this sort of thing at an early date.

Matters from Council Committees

1. *Council Liaison Committee with Blue Shield.* Dr. Kerr, chairman, announced that the Blue Shield seminar would be held on April 22 and 23, 1967.

2. *Council Liaison Committee with Blue Cross.* Dr. Taylor, chairman, reported he was unable to attend the last Blue Cross Board meeting but he had read the minutes and did not note anything that needed to be brought to the attention of the Council.

Dr. Taylor commented that he had learned that in 39 hospitals, radiologists and pathologists now are billing Blue Shield directly for their services, which represents an increase over the last report of three months ago. "I think we should keep the pressure on and recommend to the radiology and pathology groups that they do it in their meetings, and I think serious consideration might be given to inviting the members of the Blue Cross Advisory Committee to discuss this at their next meeting, with the idea that they make a recommendation to Blue Cross Board of Directors."

Dr. Rifner said that one of the recommendations in the fall from the president would be that the Council Liaison Committee with Blue Shield and a committee from Blue Shield "should meet and work out some of these problems so that neither board has to worry so much about them. If we could get an exchange of views, we wouldn't get into all this hassle about contracts; I think these things could be

worked out if everybody sat down and understood the other one's problem."

Dr. Neumann reported that at the last Blue Cross Board meeting the board discussed the fact that the psychiatrists had agreed to accept payments through the hospitals, and this matter was referred to the Psychiatric Association.

Dr. Rifner discussed this matter, saying that in his county, the psychiatrist is paid through the Mental Health Clinic under the Fisher Body contract of General Motors Plan "The psychiatrist is being paid a certain fee, determined by the Mental Health Clinic rather than by himself. So we have the same problem expanding from radiology and pathology now into psychiatry."

3. *Council Liaison Committee with I. U. School of Medicine.* Dr. Petrich, chairman, reported that his committee would meet in May and he would report to the Council at its next meeting.

4. *Council Committee for the Study and Implementation of Governmental Medical Programs.* Dr. Donato, chairman, spoke of the Medicaid program and stressed the importance of establishing some principles as to what the medical profession wants and what should be done.

Dr. Rifner urged this committee to meet and to devise a bill for Medicaid. "It behooves this committee to come up with a good bill to present to the 1969 legislature."

5. *Council Committee on Emergency Medical Services.* The chairman of the Council announced that due to health and other matters, Dr. Popp had been replaced as chairman of this committee by Dr. Lowell Hillis. Dr. Hillis presented the following report:

The AMA Conference on Emergency Medical Services was held at the Hotel Ambassador, Chicago, April 6th and 7th. The keynote address was given by Wesley W. Hall, M.D., chairman of the AMA Board of Trustees, of Reno, Nevada. Apparently this whole conference was brought about by the passage of the Highway Safety Act of 1966. He spoke of the education of physicians and a re-education of most of the physicians in the country who are directly and indirectly concerned with the care of acutely ill and injured patients. He discussed some of the numerous problems confronting organized medicine through the AMA at state and local societies, and that attempts should be made to find some of the answers to these problems in this conference. And that the conference should be a stimulus for interest in the state and local societies, as well as generating interest among our own colleagues.

Those of you who have traveled in the British Isles have seen the so-called Scottish Ambulance Service. Those of you who have

traveled in Canada have seen the ambulances of the St. John's Ambulance Service and if you sit back and realize it, the head of that group is the Queen. This is one of the problems that we're going to face either directly or indirectly through the Highway Safety Act of 1966.

The keynote address was followed by these speakers: Mr. Robert Oswald, deputy National Director of Safety Services, American National Red Cross, Washington, D. C., who spoke on "First Aid and Rescue;" William Hannon, Jr., M.D., Administrator of National Highway Safety Agency, Washington, D. C., who spoke on "Transportation of the Ill and Injured;" Mr. Robert Randall, Past-President of the Ambulance Association of America, Miami, who spoke on "Ambulance Services in the United States;" James C. Owens, M.D., Professor of Surgery, University of Colorado Medical Center, Denver, who spoke on "Emergency Communications." The fifth speaker was Richard F. Mangold, M.D., Director of the AMA Department of Hospitals and Medical Facilities, Chicago, and the sixth was Mr. Robert Sigmond, Executive Director of the Hospital Planning Association of Allegheny County, Pittsburgh, who spoke on "The Inherent Needs in Improving Emergency Medical Services."

The luncheon speaker on Thursday, April 6th, was Charles L. Hudson, M.D., of Cleveland, President of the AMA. He presented mostly general statements which will be covered later in the report, but gave much emphasis to education, and co-operation of organized medicine at the various levels. He spoke with great enthusiasm of the work of the conference and the results to be filtered back to the local level. The presentation was well received.

The conference workshops were held in the various rooms about the hotel. Each participant had been previously assigned to a workshop and had been issued a ticket for admission. There were ten such workshops, each group consisting of between 15 and 20 persons. I had been assigned to First Aid and Rescue, Committee A. Chairman of the group was Mr. Robert Oswald of the American National Red Cross. A workshop guideline had been issued and this was to serve as a basis for discussions, which developed in three groups — Number one, the components of the emergency medical system. Under that A, First Aid and Rescue, B, Transportation of the Ill and Injured, C, Emergency Communications, D, Emergency Facilities Staffing and Patient Management. The necessary ingredients for all of these components were then to be discussed and that consisted of a list of approximately eleven points. For example, training and educa-

tion, manpower planning, standards, finance and so forth.

And under three, The Roles and Responsibilities to the Components. This was another long list. As examples, the individual physician, the hospital medical staff, the state and county medical societies, medical specialty societies, allied health organizations, private citizens and so on.

These workshop discussions lasted until about 5:30 p.m., Thursday, April 6 and resumed on Friday, April 7. And these discussions continued until the luncheon Friday noon. The luncheon speaker Friday was John M. Howard, M.D., of the Department of Surgery, Hahnemann Medical College, Philadelphia. His topic was "The Future of Emergency Medical Services in the United States." Dr. Howard first gave a brief history of emergency services and then went into the predictions of the future in this age of electronics, powers of the atom and space travel. And here I marked even predicting autopsy reports within 24 hours.

This address was followed by a report of the chairman of each of the ten workshop meetings. Suffice it to say that in the six or seven hours one spent in the meetings, the subjects had been thoroughly discussed. Many conclusions had been drawn. These conclusions would make the report endless but included such things as 1.) Emergency response units, ambulances, fire equipment rescue units, helicopter law units, and so forth. 2.) Vehicle design, maintenance, inspection and equipment including automatic traffic control equipment. They gave the example that even now in one section of Philadelphia the ambulance driver can punch a button which will line up all of the lights green in front of him.

Number 3 was personnel training, minimum standards — upgrading of ambulance attendants and so forth — and especially the role of physicians which must be in this training of personnel. Number 4, communications. For example a nationwide uniform telephone number which could be used to alert aid; central dispatching units, radio and electronic communications, including such things as automatic car and plane honing devices so that if you wreck your car out on a country road, they can follow this honing device to your accident.

Number 5, the education which must start in the grade and high school level. Eventually a certain amount of first aid must become a requirement for an operator's license.

Many of the men there recommended that a certain amount of first aid training should be part of the curriculum for medical students, nurses, technicians and so forth; the

idea being that when the medical student, even though he's a freshman, goes home, he's still known to everyone in his block, his neighbors — he's "Doc," and they call on him. They also call on the nurse who is living in the community to provide first aid and so on for home accidents.

A great amount of discussion was held on emergency rooms — such as the staffing, minimum requirements, minimum standards, equipment needed in various emergency rooms, the matter of records, etc. This is by no means a complete list of the subjects, but it illustrates the depth of the discussions and the reports.

Conference summation was by Irwin E. Henderson, M.D., chairman of the AMA Committee on Emergency Medical Services, Denver. And this was concluded with a promise to Dr. Hall that the committee will work to the end that organized medicine will fulfill its emergency medical services to the public — or else it will be done for us again as has been started by the Highway Safety Act of 1966.

We were told that the conference was well covered by reporters and others for *The AMA News*. And that very shortly there will be a rather complete summary of the conference in *The AMA News*. There will be a complete report published later in booklet form which will be available to everyone concerned.

THE CHAIRMAN: Thank you, Dr. Hillis, for the excellence of your report. I think this is an important committee. . . . As you may or may not know, the Highway Traffic Safety Act of 1966 places this in the purview of the state boards of health and insists that these things be implemented because there is a provision in the law that if they are not implemented by 1969, the Federal Highway Appropriation may be, at the discretion of the director, reduced by ten percent. If we are not active in the sphere of emergency medical service, the State of Indiana runs the risk of having its appropriation reduced by ten percent.

We have a moral obligation to provide leadership in this field and Dr. Offutt agrees with this. Although he may be the official body that implements this, the state medical association has the responsibility to take the lead in this field. . . . Now we will make budgetary funds available for this committee's meetings, and I would hope that they meet regularly, diligently, and give serious consideration to these matters.

DR. REID: "J. Irwin Miller, chairman of the Presidential Committee on Medical Manpower, one of our local citizens, will be making an extensive report, and I think there is good reason to believe there will be a lot of publicity attendant on that report.

There is reason to believe that there will be great emphasis placed on not only the fact that there's a crying need for this type of service in the country, but that the medical profession generally has perhaps been a little remiss in meeting this need. . . . would assume that some of the information that they have gained in the course of their studies thus far might be available to anyone trying to set up any activities in advance of that report in June."

6. *Council Committee on Economics and Fiscal Matters*. Dr. Corcoran, chairman, discussed the following matters which he and his committee intend to study:

a. Expenditure of funds for mailings such as the poster on voluntary health agencies and legislative bulletins.

b. Per diem expenses or expense accounts for members who participate in ISMA organization work.

c. Investment of surplus funds.

Dr. Corcoran asked the executive secretary to call a meeting of this committee during the week-end of the Blue Shield meeting, April 22-23.

7. *Council Committee for Orientation of New Members*. Dr. Donato, chairman, said that since the report which he presented at the January 22, 1967, Council meeting, had been referred for further action to the Commission on Special Activities, his committee was waiting for a report from that commission.

The chairman of the Council announced that the Commission on Special Activities would meet on April 16 and Dr. Donato's committee probably could have a report by the next meeting of the Council.

New Business

Dr. Rifner explained the reasons for the delegation of officers making the trip each year to Washington. "It has been a tradition for some years for the members of the Executive Committee and one or two members of the Commission on Legislation to go to Washington once each year. During this trip we visit each and every congressman and senator from Indiana, making him aware of the health needs of this state, and also making him aware of the position of the Indiana State Medical Association regarding bills pending before Congress. . . . I think this is a worthwhile thing."

Dr. Rifner also suggested that the Council Committee on Economic and Fiscal Matters should look into the itinerary of the chairman of the Council, the chairman of the Executive Committee, and of the president-elect and the president. . . . "There may come a time when someone who is knowledgeable who we would like to have cannot serve because of his financial obligations. . . . And I think this committee

ould look into what this organization can
concerning that."

*Committee to Study Regulations on Re-
mission of Dues and Other Membership
Matters.* Dr. Bowen announced that the
membership of the committee to study
membership matters, including the remis-
sion of state dues, would be: Drs. Kerr,

Corcoran, Donato, Popp and Steen, ex-
officio.

Date for Next Council Meeting

By consent, June 11, 1967, was set for
the next meeting of the Council, at which
time the Council, the Executive Committee
and the AMA delegates and alternate dele-
gates will review the business to come be-

fore the AMA meeting at Atlantic City,
June 18 to 22, 1967.

Date for July Council Meeting

By consent, July 30, 1967, was selected
for the summer meeting of the Council.

There being no further business, the
meeting was adjourned. ◀

Saturday Drivers More Dangerous

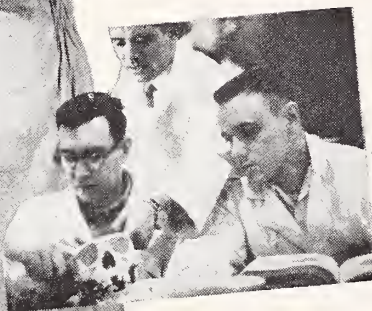
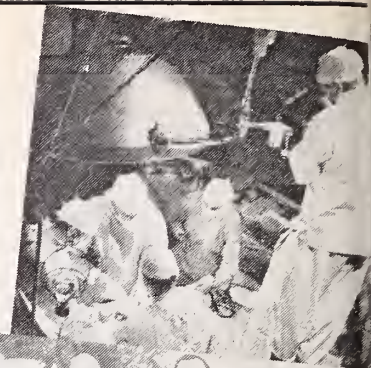
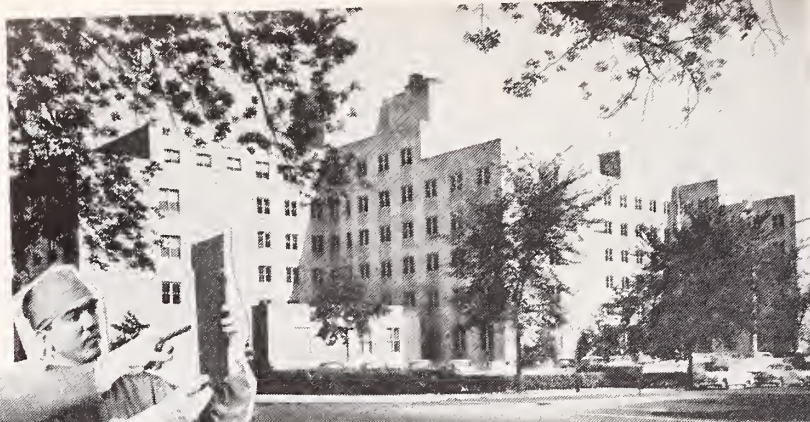
The Sunday driver has long been the target of jokes, but according to a survey by The
Travelers Insurance Companies, the Saturday shopper may be more of a menace.

More fatal accidents occur on Saturdays (21.6%) than on any other day. Sunday takes "second
honors" (18.3%).

A Travelers spokesman said drivers should pay attention to traffic—not store windows. "A
moment's distraction can cause a lifetime of agony," he added.

More than 52,500 deaths and 4,400,000 injuries were caused by highway accidents last
year. Of these, more than 11,000 deaths and 809,000 injuries occurred on Saturdays. Tuesdays
recorded the lowest number of deaths and injuries.

Passenger cars were involved in nearly 80% of all fatal accidents and almost 90% of all non-
fatal accidents. Commercial vehicles, driven many more miles per year than passenger cars,
were involved proportionately in twice as many fatal accidents as non-fatal accidents. Motor-
cycles, which constitute less than two percent of all registered vehicles, were involved in more
than two percent of all highway fatalities last year.



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

COMMERCIAL ANNOUNCEMENTS

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

AVAILABLE: Equipped physician's office available immediately due to death. Community of 2,600; drawing area of 8,000. Practice active 20 years. New location two years ago. Contact Robert A. Cox, D.D.S., 3 Parkview Court, Cambridge City, Ind. Phone 35191 for details.

DESIRED: Associate in practice, to become a partner in an established practice—surgery general and surgery of trauma, and industrial practice. Long established with all necessary equipment in a new office in a new building and a busy growing community. Prefer a man who has completed active duty requirements in service; would feel Naval Reservist would be an extra, but not essential, qualification. If you have the qualifications and are interested, write Box 339, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

WANTED: General practitioners, urologist, orthopedist needed in growing community of 15,000; service area 25,000. Present 83-bed general hospital. New 100+ bed automated hospital to be constructed within two years. City has excellent industry, school system, and recreational activity; 45 minutes from Madison or Milwaukee. Future unusually promising. For more information contact: Administrator, Watertown Memorial Hospital, Watertown, Wisconsin.

EASTERN WISCONSIN CLINIC in rapidly growing community of 50,000 desires board-eligible or certified physicians in obstetrics and gynecology, pediatrics, orthopedic surgery, urology and otolaryngology. Well-equipped clinic and excellent hospital facilities. Lake shore location offers ample recreational facilities. Attractive financial plan leading to early full partnership. Full expenses paid for applicants invited to interview. Call or write: F. L. Hildebrand, M.D., Riverside Clinic, Menasha, Wisconsin.

AVAILABLE: Office location for general practitioner or pediatrician. Attractive rental proposition. Located ten minutes from hospital in fastest growing township in Indiana. Contact R. A. Chronister, % Chronister Pharmacy, 6120 Stellan Rd., Fort Wayne, Ind. Telephone 219-483-9561.

GENERAL PRACTICE, including patients, in medical building. Fully furnished and equipped suite; all services furnished; laboratory next door; hospitals close. Doctor urgently needed in area. All of the above at NO COST to qualified doctor. Inquire R. C. Corson, 555 W. 92nd St., Indianapolis. Phone 846-8524.

CLINICAL DIRECTOR: In accredited, progressive 2,600-bed mental hospital with fully approved residency training program. Ideal living in active community in the heart of Michigan's Water Winter Wonderland vacation area. Requires Psychiatric Board Certification. Salary: \$20,984 to \$25,891. Furnished housing available, unparalleled fringe benefits. Contact M. Duane Sommerness, M.D., Supt., Traverse City State Hospital, Traverse City, Mich. 49684.

ANESTHESIOLOGIST: Community of 80,000 in north-central Indiana seeks board-certified or board eligible anesthesiologist. Hospital presently engaged in a construction and remodeling program which will have all new surgical facilities. Interested parties contact Box 340, The Journal, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

GENERAL PHYSICIAN: \$1,540 to \$1,940 a month for regular duty hours in care of patients in a mental hospital. Previous psychiatry training not necessary. Citizenship and license in Indiana. Housing and living benefits on an individually determined basis. Write or phone collect to David P. Morton, M.D., Superintendent, Beatty Memorial Hospital, Westville, Indiana 46391. Phone: (219)-785-7111.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION,** Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

SPECIAL NOTICE

June issues and the 1967-68 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis 46208.

Roster: \$3.00 each.

Yearbook: \$5.00 each

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

July 1967

Volume 60

No. 7

Ames Company, Inc.962-63	Mutual Medical Insurance, Inc.943
Ayerst Laboratories885	Parke, Davis & Company2nd Cover
Burroughs Wellcome & Co., Inc.935	Pitman-Moore Company929
Carnation Company, The892-93	Poythress, Wm. P. & Co., Inc.964-65
Geigy Pharmaceuticals925, 966-67	Robins, A. H. Company, Inc.926
Glenbrook Laboratories895	Roche Laboratories4th Cover
Hanger, J. E., Inc.975	Sandoz Pharmaceuticals936-37
Harding Hospital979	Searle, G. D. & Co.938-39
Home Lawn Mineral Springs Company974	Stuart Company, The913
Hynson, Westcott & Dunning, Inc.883	Syntex Laboratories, Inc.887-90
Indiana Medical Bureau930	Tutag, S. J. & Company973
Lederle Laboratories3rd Cover, 951, 985	Wabash Valley Hospital961
Lilly, Eli & Company906, 940-42, 968-70, 980-81	White-Haines Optical Co.947
Medical Protective Co. of Ft. Wayne982	Wyeth Laboratories899-900, 954-55

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

Indiana State Medical Ass'n Journal



J-0-P
12-67
Univ of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122

U.C. MEDICAL CENTER LIBRARY
AUG 25 1967
San Francisco 94122

IN THE NATIONAL GALLERY LONDON

THE DOCTOR By Sir Luke Fildes

Vol. 60 • No. 8 August, 1967

GENERAL PRACTITIONERS' ISSUE

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION
Indianapolis, Indiana

some allergens are green

whatever their color,
shape, or size...

Benadryl[®]

(diphenhydramine hydrochloride)

PARKE-DAVIS

for control of
allergic symptoms



Whether the allergen is greenish or garish, unseen or unknown, your patient can get symptomatic relief with BENADRYL—the potent antihistamine with antispasmodic action. **INDICATIONS:** Antihistaminic, antispasmodic, antitussive, and antiemetic therapy. **PRECAUTIONS:** Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this product. Hypnotics, sedatives, or tranquilizers if used with diphenhydramine hydrochloride should be prescribed with caution because of possible additive effect. Diphenhydramine

The pink capsule with the white band is a trademark of Parke, Davis & Company.

has an atropine-like action which should be considered when prescribing diphenhydramine hydrochloride. **ADVERSE REACTIONS:** Side effects are generally mild and may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, blurring of vision, vertigo, headache, muscular aching, thickening of bronchial secretions, restlessness, and insomnia have been reported. Allergic reactions may occur.

BENADRYL is available in Kapseals[®] of 50 mg. and Capsules of 25 mg.

00867

PARKE-DAVIS

Lutrexin[®]

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA
AND SELECTED CASES OF PREMATURE LABOR AND 2ND
AND 3RD TRIMESTER THREATENED ABORTION**

In controlling abnormal uterine activity, LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be the drug of choice by many clinicians.

No side effects have been reported, even when massive doses (25 tablets per day) were administered.

Literature on indications and dosage available on request.

Supplied in bottles of twenty-five 3,000 unit tablets.

HYNSON, WESTCOTT & DUNNING, INC.

BALTIMORE, MARYLAND 21201



(LTR22)

in vivo measurement of LUTREXIN (Lututrin) on contracting uterine muscle of the guinea pig.



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Clinical Usefulness of the Diuretic Triamterene , Jack T. Collins, M.D., Bluffton ...	1027
Cellular Development and Heredity , (Report on the American Cancer Society-sponsored work at the laboratory of Dr. Tracy M. Sonneborn, Bloomington)	1036
Treatment of Arrhythmias Following Myocardial Infarction , A. D. Dennison, Jr., M.D., William R. Storer, M.D., Indianapolis	1039
Intensive Coronary Care Units , William R. Storer, M.D., Indianapolis	1043
Tuberculosis Treatment and Follow-up , John D. Miller, M.D., Indianapolis	1045
The Case of Iatrogenic Idiopathy , Arnold Lieberman, M.D., New York, N.Y.	1049
The Cancer You View , Charles R. Thomas, M.D., Indianapolis	1053
Electrocardiogram of the Month: Pulmonary Emphysema vs. Myocardial Infarction , Charles Fisch, M.D., Indianapolis	1054
Fractures and Orthopedic Problems: Fracture of the Distal Radius with Ulnar Nerve Injury , William A. Stark, M.D., Michigan City	1058
X-Ray Conference: Massive Pulmonary Infarction , Erich K. Lang, M.D., Indianapolis	1059
Path-finder: The Routine Throat Culture	1067

EDITORIALS

The Doctor is Losing His Voice , Paul Harvey, ABC Commentator, Chicago, Ill. (abstract)	1069
The Social Security Disability Program in Indiana	1070
PMA President Replies to Critics	1070
Advertising Income of Nonprofit Organizations	1070
Patient Selection for Coronary Care , A. D. Dennison, Jr., M.D., Indianapolis	1070
Editorial Notes	1071

SPECIAL FEATURES

What's New?	1016
Meet The Journal Staff	1073
The Doctor is Losing His Voice , Paul Harvey, ABC Commentator, Chicago, Ill.	1078
Report of Actions of the AMA House of Delegates , 116th Annual Convention, June 18-22, 1967, Atlantic City	1089
Open Letter to All Indiana Physicians: Testing of School Children for Tuberculosis , the Indiana State Board of Health	1096

REGULAR FEATURES

Month in Washington	1009
Fourth Estate	1021
Letters to the Editor	1025
From The Journal 50 Years Ago	1038
President's Page	1074
The Woman's Auxiliary Reports to ISMA	1077
News from Indiana University School of Medicine	1083
Medical Panorama: Hoosier Population Trends , A. W. Cavins, M.D., Terre Haute ..	1095
Changes in Blue Shield Payment Patterns (One of a Series)	1098
Wanted: Locations, Physicians	1100
Medicine At Law	1107
Abstracts, Book Reviews	1113
News Notes	1118
Annual Meeting Dates of Professional Medical and Allied Organizations	1121
Board of Health Report	1124
Future Meetings, Seminars, Courses	1125
County, District News	1126
Deaths	1126

BUSINESS

Executive Committee: June 10, 1967	1127
The Council: June 11, 1967	1128

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

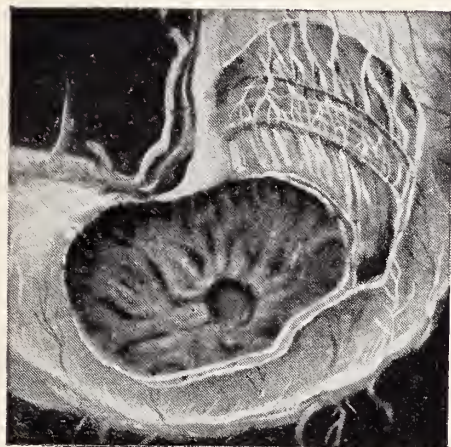
Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Paplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 1033.

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED
COMBINATION
OF THE MOST WIDELY
USED ANTACIDS—
FOR RAPID
NEUTRALIZATION.
PLUS SIMETHICONE—
TO CONTROL
THE FACTOR WHICH
ANTACIDS ALONE
CANNOT INFLUENCE.

Mylanta[®]

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 9-12, 1967—INDIANAPOLIS

OFFICERS FOR 1967-68

President—Eugene S. Rifner, M.D., Von Buren 46991.

President-Elect—G. O. Lorson, M.D., 1110 Indiana Ave.,
LoPorte 46350.

Treasurer—Ottis N. Olvey, M.D., 3231 N. Meridian, #11,
Indianapolis 46208.

Assistant Treasurer—Lester H. Hoyt, M.D., Methodist Hospital,
Indianapolis 46207.

Executive Secretary—Mr. James A. Woggener, 3935 N.
Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N.
Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935
N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scotts-
burg 47170.

Field Secretary—Mr. Howard Grindstoft, 3935 N. Meridian,
Indianapolis 46208.

Legal Counselor—Mr. Robert Hollowell, 1440 Consolidated
Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Romsey, M.D., 1802 N. Illinois
St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stohl, 3935 N. Meridian,
Indianapolis 46208.

COUNCILORS

District	Term Expires
1—P. J. V. Corcoran, Evansville.....	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1967
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—William R. Tindall, Shelbyville	Oct. 1967
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1967
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—Milton F. Popp, Fort Wayne	Oct. 1967
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	1967
2.....
3—Elmer L. Wolloce, New Albany	1968
4—Jock E. Shields, Brownstown	1967
5—A. W. Covins, Terre Haute	1967
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1967
9—Clarence G. Kern, Lebanon	Fall, 1968
10—Hermon Wing, Gory	1969
11—James A. Horshmon, Kokomo	1969
12—William Clark, Fort Wayne	Spring, 1968
13—George B. Gottman, Elkhart	1967

SECTION OFFICERS 1967-68

Section on Surgery:

Chairman—Joseph C. Finneron, Indianapolis
Vice-chairman—Donald M. Schlegel, Indianapolis
Secretary—Henry Larzelere, Marion

Section on Internal Medicine:

Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sondock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—Lewis E. Morrison, Indianapolis
Vice-chairman—M. Richard Hording, Indianapolis
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—Eugene Schmidt, Fort Wayne
Vice-chairman—William M. Matthews, Indianapolis
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Ross Egger, Middletown
Vice-chairman—Joy S. Reese, Martinsville
Secretary—Robert Mouser, Indianapolis

Section on Obstetrics and Gynecology:

Chairman—Joseph F. Thompson, Indianapolis
Vice-chairman—Robert M. Reid, Columbus
Secretary—Tom W. Wochob, Jr., Kokomo

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neel Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Louis C. Bixler, Bloomington
Vice-chairman—Richard A. Silver, Indianapolis
Secretary—William M. Anshutz, Indianapolis

Section on Nervous and Mental Diseases:

Chairman—Donald F. Moore, Indianapolis
Vice-chairman—Hons Meyer, Westville
Secretary—Gene E. Lynn, Indianapolis

Section on Pathology:

Chairman—Joseph L. Haymond, Indianapolis
Vice-chairman—Robert J. Frost, Michigan City
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Roland E. Miller, Lafayette
Vice-chairman—Wendell E. Brown, Indianapolis
Secretary—Morris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1967:

Delegates

Guy A. Owsley
Hortford City

Alternates

Maurice E. Glock
Fort Wayne

Jock E. Shields
Brownstown

Dwight W. Schuster
Indianapolis

Terms expire December 31, 1968:

Delegates

Harold C. Ochsner
Indianapolis
Eugene F. Senseny
Fort Wayne
Frank H. Green
Rushville

Alternates

James H. Gosman
Indianapolis
Robert M. Brown
Marion
Kenneth O. Neumann,
Lafayette



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"

The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; Eugene S. Rifner, Van Buren, President; G. O. Larson, LaPorte, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Ottis N. Olvey, Indianapolis, Treasurer; Lester H. Hoyt, Indianapolis, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Glock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis, secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salom, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Gootee, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Glock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholty, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hovda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Okla W. Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Markleville; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseny, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordsville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salom, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammond; Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry G. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donald M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordsville.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowe! H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Hobgood, Evansville	
2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Frank B. Bard, Crothersville	Harold E. Miller, Seymour	
5.	Thomas J. Conway, Terre Haute	Arnold W. Kunkler, Terre Haute	
6.	J. J. Farrell, Jr., Greenfield	Perry Seal, Brookville	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	
10.	R. James Bills, Gary	John J. Reed, Hobart	
11.	Joseph Bean, Logansport	Fred Poehler, La Fontaine	Logansport, Sept. 13, 1967
12.	Max M. Gitlin, Bluffton	Berniece Williams, Fort Wayne	
13.	Gordon Cook, South Bend	John Hildebrand, South Bend	South Bend, Sept. 27, 1967

Professional Life's

NEW! PARTICIPATING WHOLE LIFE INSURANCE

*We Invite You
To Compare...*

- LOW GROSS PREMIUMS
- HIGH EARLY CASH VALUES
- ATTRACTIVE POLICY DIVIDENDS

A ledger statement illustration tailored to your specific age, which is available on your request, will quickly identify the benefits and values of Professional Life's New Participating Whole Life Insurance.

We welcome your comparison of the high values and the low net costs with rates available from any other life insurance company.

ILLUSTRATION OF PREMIUMS AND POLICY VALUES
PER \$1,000 OF INSURANCE

Age at Issue	Annual Premium	20th Year Policy Values	
		Accumulated Cash Value	Accumulated Dividends*
24	\$12.90	\$261.59	\$ 63.53
25	13.30	269.31	65.79
26	13.75	277.16	68.98
27	14.20	285.14	72.27
28	14.65	293.24	75.78
36	19.45	361.30	107.90
37	20.20	370.12	112.51
38	21.00	378.99	117.07
39	21.80	387.92	121.77
40	22.65	396.90	126.55
41	23.60	405.91	131.45
42	24.55	424.02	141.43
54	40.95	516.77	222.19
55	42.90	524.54	230.31
56	44.95	532.38	238.53
57	47.10	540.25	246.76

*Dividend illustrations included above are based on present scale and are neither guarantees nor estimates for future years.

**MINIMUM
ISSUE
\$10,000**



**Professional Life
& Casualty Company**

HOME OFFICE: 720 N. Michigan Ave.,
Chicago, Ill. 60611

EDWIN S. HAMILTON, M.D., Chairman
EDWARD L. COMPERE, M.D., President
NORMAN R. B. KING, General Manager

**WRITE
TODAY**

A "ledger statement illustration" tailored to your specific age is available upon request, without obligation. Just fill out the attached coupon and mail today.

PLEASE SEND ME A "LEDGER STATEMENT ILLUSTRATION" TAILORED TO MY AGE, WITHOUT ANY OBLIGATION ON MY PART.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____

867 IN Month Day Year

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe
Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Griffith Marr, Columbus
A. L. Coddens, Earl Park
Robert H. Wiseheart, Lebanon
Don J. Wagoner, Delphi
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
J. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazey, Washington
Alfred K. Rhodes, Lawrenceburg
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
William E. Garner, Jr., New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waitt, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
James S. McElroy, New Castle
Donald Fields, Kokomo
Reeve Peare, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisetti, Madison
George Brown, Greenwood

Boyd K. Black, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford
Robert D. Williams, Markleville
William B. Lybrook, Indianapolis

Marshall Stine, Bremen
Parker W. Snyder, Peru
Claude N. Thompson, Waynetown
Ellery T. Drake, Martinsville
John Parker, Goodland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington
John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Glackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Philip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
H. H. Dunham, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David G. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave.,
Fort Wayne
Mr. Larry L. Pickering, Exec. Secy.,
212 Med. Ctr. Bldg., Fort Wayne
Donald L. Sandlin, 2530 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
James R. McAfee, 1005 N. East, Lebanon
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street,
Logansport
Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St.,
Frankfort
C. Philip Fox, 305 Peoples Bank, Washington
J. Kenneth Jackson, 223 Mechanic St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntingburg
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman
Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert G. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren
William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St.,
Franklin
John S. Murray, 317 Security Bank Bldg.,
Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave.,
Gary
Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave.,
LaPorte
Joseph D. McPike, 1714 24th St., Bedford
William M. Stimson, 333 Jackson St., Anderson
Charles W. Cure, 1815 N. Capitol Ave.,
Indianapolis
Mr. Arthur G. Loffin, Exec. Secy., 2902 N.
Meridian, Indianapolis
Cecil R. Burket, 424 W. South St., Bremen
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 10½ N. Main St., Martinsville
Arthur Schoonveld, Brook
Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Charles Emery, 400 E. 3rd St., Bloomington
Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital,
Valparaiso
Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe,
South Bend
Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E.
3rd., Evansville
Robert L. Meissel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City

HOW LIKE IS "LIKE"?

Lately, you have been urged to use a semi-synthetic penicillin as though it were a broad-spectrum antibiotic.

Should you? In the face of the fact that the Council on Drugs of the American Medical Association has for some time advised against it?¹ And now the new (1967) United States Dispensatory says much the same thing, in even stronger terms—that the drug in question is neither a broad-spectrum antibiotic in the sense that the tetracyclines are, nor is it even the first penicillin with a wider range of antibacterial action.²

Should you, for example, in treating pneumonia? The rationale for using this penicillin in pneumonia is that it is effective against *Hemophilus influenzae* as well as against *Diplococcus pneumoniae*.

So, be it noted, is DECLOMYCIN.

But what about *Mycoplasma pneumoniae*, which may be better known to you as Eaton Agent? No penicillin is known to be effective against this common cause of pneumonia. DECLOMYCIN is.

Some believe that *Mycoplasma pneumoniae* may be responsible for upwards of 30 per cent of all cases of pneumonia.³ Could this mean that if you employ a penicillin in pneumonia when the etiological agent is unknown, there may be an automatic 30 per cent chance of failure?

When you consider using a drug *like* a broad-spectrum antibiotic, why not use a *true* broad-spectrum antibiotic? Like DECLOMYCIN.

References: 1. A.M.A. Council on Drugs: *New Drugs* 1966 ed. Chicago: American Medical Association, p. 12. 2. Osol, A.; Pratt, R., and Altschule, M.D.: *The United States Dispensatory*, 26th ed. Philadelphia: J. B. Lippincott Co., 1967, p. 844. 3. Purcell, R. H., and Chanock, R. M.: Role of Mycoplasmas in Human Respiratory Disease. *Med. Clin. N. Amer.* 51:791 (May) 1967.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE



Prescribing information
on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

TRUE BROAD SPECTRUM

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D. C.—John W. Gardner, secretary of Health, Education and Welfare, called on the medical profession and others in the health field to "search for new and less expensive ways of doing things."

THIS was the main theme of his talk at the windup session of a two-day National Conference on Medical Costs attended by 300 physicians, hospital administrators and other leaders in the various aspects of health care. He said the conference discussions "reflected a universal recognition that change is necessary."

"WE CANNOT go on as we have in the past," Gardner said. "New patterns will be necessary. Those who entertain some apprehension as to what the new patterns will be had better plunge in and experiment with their own preferred solutions Standing back and condemning the solutions that others devise won't stem the tide of change. . . .

". . . THERE is not yet any agreement as to what a more perfect system would look like. It seems likely that we will go through a period of experimentation and in true American fashion may end up with several variations in different parts of the country, suiting local preferences and conditions.

"WHETHER the health care system or the future should develop around the hospital as an organizational focus, or around the payment mechanism, or around group practice plans, or around all of these in some sort of collaboration with state health planning councils — or whether other variants will emerge — is still a wide-open question

"ESSENTIALLY . . . the challenge is before the health profession. They must join the search for solutions. They must be willing to re-examine and overhaul long-established practices. The search for new and better and less expensive ways of doing things must be carried on by hospitals, medical schools, community agencies and by the thousands of individual physicians serving the health needs of people"

ACCEPTANCE of such responsibility by those in the private sector, Gardner said, "is the best insurance against the government having to shoulder more than its share of corrective measures."

CITING appointment of an advisory committee to study hospital effectiveness, Gardner said that HEW will do its part in the search for more efficient practices. The committee is to report by the end of this year.

DR. MILFORD O. ROUSE, president of the AMA, commended the Administration "for

showing its concern for rising health care costs by calling a national conference on the problem.

"THE American Medical Association and its member physicians pledge to accept their responsibilities in finding solutions to this vital problem," he said. "We expect that other full members of the health team — dentists, hospitals, nurses, pharmacists and pharmaceutical companies, the insurance industry and others — will do likewise.

"WE HOPE the Administration will also accept its responsibility to find ways to ease the burden of inflation which contributes substantially to inflating the cost of medical care. We hope the Administration will call a moratorium on new health legislation until existing programs can be critically evaluated to eliminate overlapping and duplication and to achieve maximum conservation of tax funds. We hope available tax money, particularly in the health field, can be used to help those who really need help while allowing our more fortunate citizens to accept responsibility for their own care."

BILL PASSED TO EXTEND CONSTRUCTION GRANTS

CONGRESS passed and President Johnson signed into law a bill that extends the program of grants for the construction of community health centers for three years (until June 30, 1970.)

IT AUTHORIZES the appropriation of \$50 million for fiscal year 1968 and \$70 million for 1970.

THE AMENDED LAW also extends the program of grants for the initial staffing of community mental health centers for an additional two years (until 1970) and authorizes the appropriation of \$26 million for fiscal 1969 and \$32 million for fiscal 1970. An appropriation of \$30 million already was authorized for fiscal 1968.

PRESIDENT EXTENDS DRAFT FOR FOUR YEARS

PRESIDENT JOHNSON signed into law legislation extending the draft for four years. It includes a provision continuing special pay for physicians and dentists.

THE NEW LAW also continues the authority to defer medical students until completion of internship. In the future, foreign physicians in this country will be liable to draft up to age 35 — the same as for Americans. Under the old law, foreign physicians were exempt from age 26.

THE present blanket military exemption for Public Health Service officers serving on loan to other agencies such as the Food and Drug Administration was removed despite protests by the agencies involved. Such assignments with draft exemption can now be made only to the Coast Guard, Bureau of Prisons and Environmental Services Administration. The American Medical Association had asked Congress to allow no draft exemptions for non-military service.

AMA NOT OPPOSED TO MEDICAL CARE FOR THE POOR

THE president of the American Medical Association said that Sargent Shriver, Director of the Office of Economic Opportunity, was in error when he accused the AMA of being opposed to medi-

cal care for the poor because the AMA is opposed to the OEO's slum health care centers.

ILFORD O. ROUSE, M.D., Dallas, Texas, the AMA president, said the AMA is opposed to the OEO projects because the health care problems in the slums can be taken care of under existing programs, particularly Medicaid.

"THERE is already too much proliferation of wasteful, overlapping federal health programs," Dr. Rouse said.

"ALSO of concern to physicians is the fact that at times it seems that government is too quick to set up health care programs without consulting with those who know most about health care—physicians."

THE AMA president also said Shriver was misinformed about the AMA's position on helping those who need help.

"I AM NOW and always have been in full accord with AMA's long-standing position that those who need help in financing health care should receive it," Dr. Rouse said.

"THE AMA, however, is opposed to the doling out of tax funds to the wealthy and well-to-do. The expenditure of public funds for those who can well afford to finance their own health care limits the amount of resources available to those who do need it. Such a policy cannot be justified morally or economically." ◀

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

(Phone)

W. R. VanDenBosch, M.D.

447-6404

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

David L. Evans, M.D.

743-1809

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

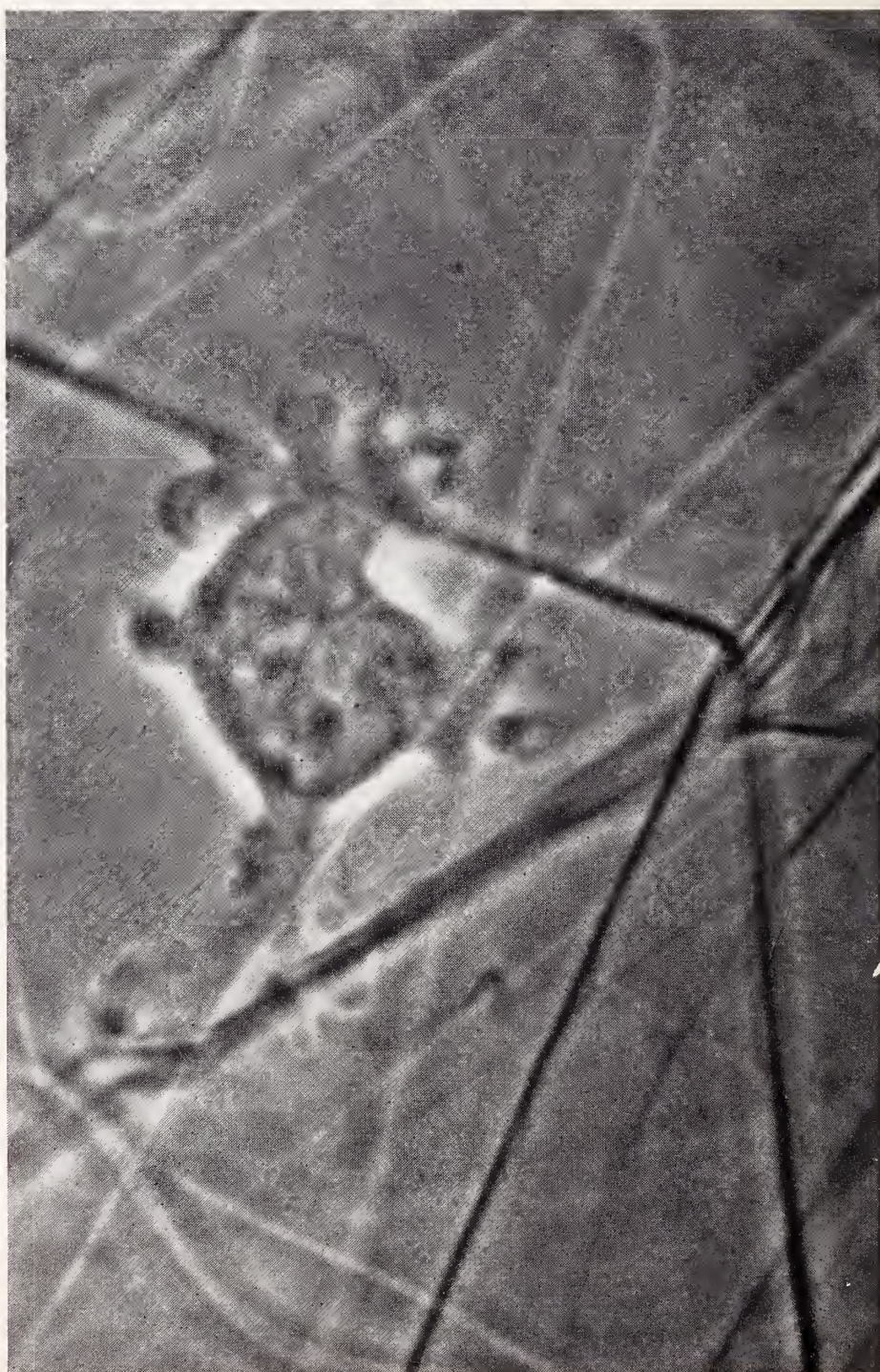
All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

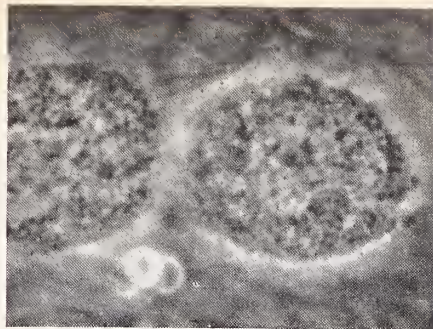
INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

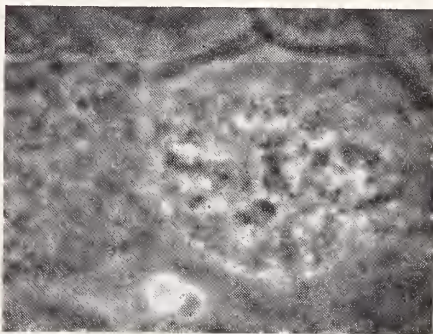
You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.





Phase-contrast microscopy showing mast cell before injury.



Mast cell (after injury) has broken up and released cytotoxins.

Visual evidence of how corticosteroids influence the inflammatory reaction

Working with phase-contrast cinematography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

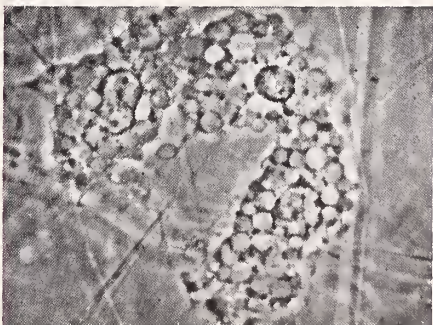
In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.

How corticosteroids change the picture

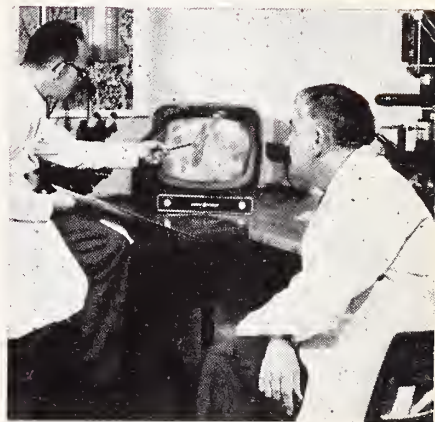
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid — Synalar (fluocinolone acetonide) — the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.

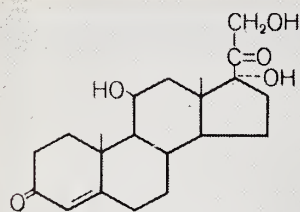


In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

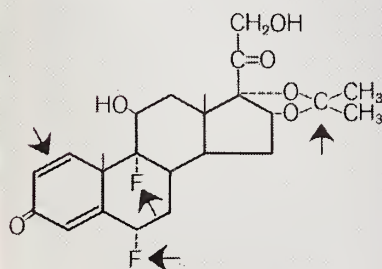
*A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more corticosteroid. And it can often do it more effectively.



Hydrocortisone



Fluocinolone Acetonide (Synalar)

- a double bond between carbons 1 and 2
- fluorine substitutions at both the 6- α , and the 9- α positions
- the addition of the acetonide at the 16- α , 17- α positions, thus providing one of the most potent topical corticosteroids available.

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY¹⁻⁴ is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B— injected with 1, 2 and 4 mg. of hydrocortisone— show progressively smaller thymuses as does Group C— injected with fluocinolone acetonide— but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY¹⁻⁴ also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*

Efficacy Documented in over 4,000 Patients

Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964. vol. III. pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory
dermatoses...
by any measure
a topical corticosteroid
of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram
one of the most active topical
corticosteroids available

Rapid and predictable
in antiinflammatory and
antipruritic activity

Results often comparable to
those of systemic corticosteroids
with fewer hazards



After the picnic even Gramps Was a victim of intestinal cramps

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

In elderly patients it is particularly important to stop the diarrhea fast. Parepectolin helps you control diarrhea promptly and gain the patient's confidence until etiology has been determined.



Parepectolin®

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

Usual Adult Dose: One or two tablespoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

What's New?

Smith Kline and French announce FDA approval of a new prescription drug "Vontrol" for treatment of vertigo, nausea and vomiting. A low incidence of side effects is reported. The effectiveness of the preparation was, in part, demonstrated by relief of symptoms in Menier's disease and following inner-ear surgical procedures.

* * *

Eli Lilly has introduced a new four-gram package of Keflin. The new sized ampoule will make the preparation of large intravenous doses more convenient. This is in conformity with the new maximum recommended limit of daily dosage at 12 grams, which is sometimes advantageous, although lesser doses are usually adequate. The package insert literature contains a revised list of indications and some new qualifications. Reference is made to the use of Keflin in peritoneal dialysis procedures.

* * *

The AMA has just published a question and answer book entitled "Let's Talk About Food", written for the public and dealing with the best questions and answers which have appeared in the monthly column in *Today's Health*. It was published because of the importance of food and proper diet, and because of the faddism and fanaticism which pervades the public's concept of nutrition. The book may be ordered at the cost of \$1.20 per copy from the AMA, 535 N. Dearborn, Chicago, 60610.

* * *

American Cystoscope Makers have exclusive rights to market Lubraseptic Jelly under an agreement with Guardian Chemical Corporation. The jelly is an anesthetic and antibacterial lubricant for medical and surgical use. It is water-soluble and does not contain any "caines" or antibiotics. It becomes completely fluid when expelled under pressure from its tube, but immediately returns to a jellied state.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



Schering

**we know
that you won't
be convinced
until you try
Drixoral
yourself**

Most oral decongestants produce adequate or good results in most patients with rhinitis and other U.R.I. disorders.

An oral decongestant's bid for superiority must be justified by a demonstrated increase in excellent results in *more* patients. And that is exactly what double-blind and crossover studies have indicated about a coming entry into the oral decongestant field from Schering.

Next month, you will be able to prescribe DRIXORAL Sustained-Action Tablets twice daily for 24-hour relief of upper respiratory mucosal congestion in seasonal and perennial nasal allergies, acute rhinitis and rhinosinusitis, acute and subacute sinusitis, eustachian tube blockage, and secretory otitis media.

**available
from Schering
next month
DrixoralTM**

Sustained-Action Tablets
brand of dexbrompheniramine maleate
and d-isoephedrine sulfate

Each tablet contains
dexbrompheniramine maleate 6 mg.,
and d-isoephedrine sulfate 120 mg.

**but you can
try it
sooner**

**More details
on Drixoral and
this mechanical man
next month.**

**Schering
introduces
DrixoralTM**



**Double-blind
and crossover studies¹⁻³
show superior results
with an
oral decongestant,
but...**

**see
previous page
for special
pre-introductory
sample offer for
New DrixoralTM**

**Sustained-Action Tablets
brand of dextbrompheniramine maleate
and d-isoephedrine sulfate**

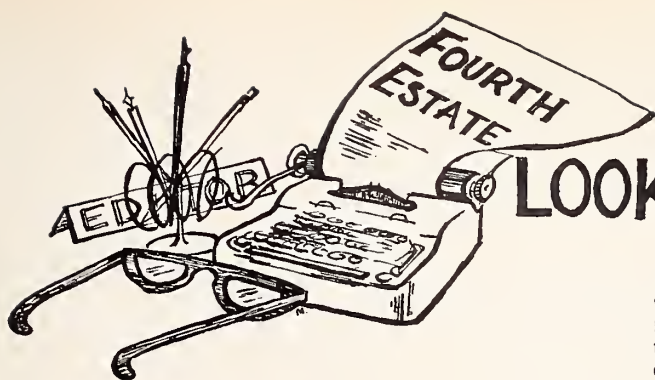
**Each tablet contains dextbrompheniramine maleate 6 mg.,
and d-isoephedrine sulfate 120 mg.**

Clinical considerations: Contraindications—DRIXORAL should not be given to children under 12 years of age. Until animal studies support the safety of this preparation for use during gestation, DRIXORAL should not be administered to pregnant women. Precautions—Although isoephedrine causes precisely no pressor effect in normotensive individuals, it should be used with caution in patients with hypertension, coronary artery disease and hyperthyroidism. Dextbrompheniramine maleate may cause infrequent and usually mild drowsiness; should this occur, the patient should not engage in mechanical operations that require alertness. Side effects—Mild drowsiness has been observed in occasional patients receiving DRIXORAL. Although very infrequent complaints suggestive of sympathomimetic side effects have been noted, possible side effects of sympathomimetic origin include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, swelling, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesical sphincter spasm. For more complete details, consult package insert or Schering literature available from your Schering Representative or Medical Services Department, Union, New Jersey 07083.

References:

1. Pullen, F. W. 2nd, and Montgomery, W. W.: Arch. Otolaryng. 77:24, 1963.
2. Frenk, D. I.: Curr. Therap. Res. 6:158, 1964.
3. Flierberg, A. A.: Ann. Allergy 22:324, 1964.

S-281



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

PERSONALLY SPEAKING

Social Security Swindles The Young

By Jameson G. Campaigne

(Editor of The Star)

(Last of Three Columns)

Last Sunday and Monday I pointed out in this column that government social insurance now costs taxpayers more, and pays out less in benefits, than private insurance, annuity, pension or investment programs. I charged it was a fraud on the young worker in the United States.

I received some critical letters from people already retired on Social Security. They said they were receiving more today from Social Security than they and their employers paid into the program.

They are so right! They get more than they paid in because many have been let into the program in the last few years; there are millions of new taxpayers paying their benefits; taxes have been raised to five times what they were when the program started; the "Trust Fund" is not paying these beneficiaries—the tax payments of people working *today* are paying them. Young people will not get more than they paid in, not if they live to be 100, as *Barron's Weekly* points out.

"The program," said *Barron's*, "has become an out and out swindle on the young people now entering the labor force . . . they will never get back what they and their employers contribute to the insurance fund."

Recently *Newsweek* quoted economist Paul A. Samuelson of MIT as saying, "The beauty about social insurance is that it is actuarially unsound. Everyone (now) who reaches retirement age is given benefit privileges that far exceed anything he has paid in"

"How is this possible? It stems from the fact that the national product is growing at compound interest and can be expected to do so as far as the eye can see. Always there are more youths (to pay taxes) than old folks in a growing population. More important . . . the taxable base upon which the benefits rest in any period are much greater than the taxes paid historically by the generation now retired. . . ."

For financing Social Security "a growing nation is the greatest Ponzi game ever contrived."

So it is. But a swindle is a swindle whether done by Ponzi, a notorious Boston swindler in the '20s, or the Federal government.

What Samuelson is saying is that as more young people go to work and pay Social Security taxes, their money pays the old people who are retired. The old people's money has already been spent. He is also assuming that population and income will always continue to grow so more young people paying taxes can pay higher benefits to those retiring—forever.

These assumptions are not borne out by history. Birth rates in this country have fallen since the baby boom after the war. Productivity has

fallen to less than 1.5% annually. And now it is proposed to increase Social Security taxes to 5.8% in 1987 and increase the taxable income on which it is paid from \$6,600 to \$10,800!

The program today lays almost the entire burden on the young and middle aged worker. These people have no chance of getting back in pensions what they and their employers contribute to it. If they invested this money in private insurance or investment programs they would be twice, three times or four times as well off at age 65.

Within the next 10 years the majority of American taxpayers—and voters—will be under the age of 30. Will they be willing to be swindled forever? I don't think so. If they are not, they will force Congress to cut back both taxes and spending on Social Security. Income limits will be imposed. Means tests will be instituted. If the burden is too great even retirement benefits may be cut back. The majority rules in a democracy, after all.

And this is the danger. An unsound program should be changed before it goes broke. That is why I proposed a voluntary—or rather optional—program. Those who cannot or will not invest for their future should be kept in the program and any additional costs paid from general tax revenues. Those who can and do save, in approved programs, should be given a choice—get out or stay in. Most will choose to get out and invest in private programs when



**see
previous page
for special
pre-introductory
sample offer for
New DrixoralTM**

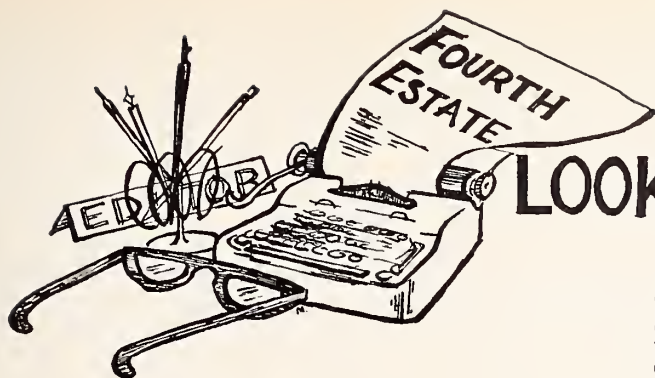
**Sustained-Action Tablets
brand of dexbrompheniramine maleate
and d-isoephedrine sulfate**

**Each tablet contains dexbrompheniramine maleate 6 mg.,
and d-isoephedrine sulfate 120 mg.**

Clinical considerations: Contraindications—DRIXORAL should not be given to children under 12 years of age. Until animal studies support the safety of this preparation for use during gestation, DRIXORAL should not be administered to pregnant women. *Precautions*—Although isoephedrine causes practically no pressor effect in normotensive individuals, it should be used with caution in patients with hypertension, coronary artery disease and hyperthyroidism. Dexbrompheniramine maleate may cause infrequent and usually mild drowsiness; should this occur, the patient should not engage in mechanical operations that require alertness. *Side effects*—Mild drowsiness has been observed in occasional patients receiving DRIXORAL. Although very infrequent complaints suggestive of sympathomimetic side effects have been noted, possible side effects of sympathomimetic origin include anxiety, tension, restlessness, nervousness, tremor, weakness, insomnia, headache, palpitation, tachycardia, angina, elevation of blood pressure, sweating, mydriasis, anorexia, nausea, vomiting, dizziness, constipation, and dysuria due to vesical sphincter spasm. For more complete details, consult package insert or Schering literature available from your Schering Representative or Medical Services Department, Union, New Jersey 07083.

References:

1. Pullen, F. W. 2nd, and Montgomery, W. W.: Arch. Otolaryng. 77:24, 1963.
2. Frank, D. I.: Curr. Therap. Res. 6:158, 1964.
3. Fierberg, A. A.: Ann. Allergy 22:324, 1964.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

PERSONALLY SPEAKING

Social Security Swindles The Young

By Jameson G. Campaigne

(Editor of The Star)

(Last of Three Columns)

Last Sunday and Monday I pointed out in this column that government social insurance now costs taxpayers more, and pays out less in benefits, than private insurance, annuity, pension or investment programs. I charged it was a fraud on the young worker in the United States.

I received some critical letters from people already retired on Social Security. They said they were receiving more today from Social Security than they and their employers paid into the program.

They are so right! They get more than they paid in because many have been let into the program in the last few years; there are millions of new taxpayers paying their benefits; taxes have been raised to five times what they were when the program started; the "Trust Fund" is not paying these beneficiaries—the tax payments of people working *today* are paying them. Young people will not get more than they paid in, not if they live to be 100, as *Barron's Weekly* points out.

"The program," said *Barron's*, "has become an out and out swindle on the young people now entering the labor force . . . they will never get back what they and their employers contribute to the insurance fund."

Recently *Newsweek* quoted economist Paul A. Samuelson of MIT as saying, "The beauty about social insurance is that it is actuarially unsound. Everyone (now) who reaches retirement age is given benefit privileges that far exceed anything he has paid in

"How is this possible? It stems from the fact that the national product is growing at compound interest and can be expected to do so as far as the eye can see. Always there are more youths (to pay taxes) than old folks in a growing population. More important . . . the taxable base upon which the benefits rest in any period are much greater than the taxes paid historically by the generation now retired. . . ."

For financing Social Security "a growing nation is the greatest Ponzi game ever contrived."

So it is. But a swindle is a swindle whether done by Ponzi, a notorious Boston swindler in the '20s, or the Federal government.

What Samuelson is saying is that as more young people go to work and pay Social Security taxes, their money pays the old people who are retired. The old people's money has already been spent. He is also assuming that population and income will always continue to grow so more young people paying taxes can pay higher benefits to those retiring—forever.

These assumptions are not borne out by history. Birth rates in this country have fallen since the baby boom after the war. Productivity has

fallen to less than 1.5% annually. And now it is proposed to increase Social Security taxes to 5.8% in 1987 and increase the taxable income on which it is paid from \$6,600 to \$10,800!

The program today lays almost the entire burden on the young and middle aged worker. These people have no chance of getting back in pensions what they and their employers contribute to it. If they invested this money in private insurance or investment programs they would be twice, three times or four times as well off at age 65.

Within the next 10 years the majority of American taxpayers—and voters—will be under the age of 30. Will they be willing to be swindled forever? I don't think so. If they are not, they will force Congress to cut back both taxes and spending on Social Security. Income limits will be imposed. Means tests will be instituted. If the burden is too great even retirement benefits may be cut back. The majority rules in a democracy, after all.

And this is the danger. An unsound program should be changed before it goes broke. That is why I proposed a voluntary—or rather optional—program. Those who cannot or will not invest for their future should be kept in the program and any additional costs paid from general tax revenues. Those who can and do save, in approved programs, should be given a choice—get out or stay in. Most will choose to get out and invest in private programs when

they understand how much better off they will be.

It is interesting to note that already there is 13 *times as much money* available to pay private pensions in the U.S. as there is in the "Trust Fund" in government bonds. That tells us something, doesn't it?—*The Indianapolis Star*, March 26, 1967.

They Earned It

There is no way to measure the good that comes from the dedicated effort given to relieve the plight of those who suffer from cerebral palsy. It is immeasurable.

The sufferers from this crippling affliction are terribly handicapped. Hope for the improvement of their condition lies with such dedicated people as Dr. Carl D. Martz, clinical professor of orthopedic surgery at the Indiana University Medical School. He has worked in and with the cerebral palsy clinic since he first was a resident physician there in 1943-44.

Public recognition came to him Sunday night when Robert W. Newell, president of United Cerebral Palsy of Central Indiana, presented Martz the Charles P. Willis award for outstanding contributions to the cause of the cerebral palsied.

An audience of 500 was on hand to applaud the award, well aware that Dr. Martz' understanding, sympathy and knowledge had done much to improve the lot of the palsied. And there also was applause for each of the 85 high school and junior high school pupils who had given thousands of hours of volunteer work to helping and caring for palsied children, and who received certificates.

Not only have the palsied children received beneficial care and attention as a result, but this work has also provided opportunity for the parents of the afflicted to be relieved from the constant attention that is required.

The young volunteers themselves have indirectly benefited from their

self-imposed duties in acquiring a mature sense of values and responsibilities. They along with Dr. Martz have more than earned the honors that have come to them.—*The Indianapolis News*, May 23, 1967.

JOHN SCOTT'S 'EDITOR'S FILE'

Doctors Wading Into Mainstream Of Affairs Bolster Medicine's Image

In the fortnight just finishing this writer has spoken at two dinner meetings where individual citizens were honored for service to their community.

At each affair one of the honored guests was a doctor of medicine who had performed unusual civic service unrelated to his profession.

A dinner in Lafayette or in South Bend does not by any means represent an isolated instance of doctors wading into the mainstream of the community. Obviously there is a trend in the medical profession toward greater participation in civic affairs and politics.

Forgetting at this point the altruism involved on the part of the individuals, this wading-in process from the standpoint of their public relations is long overdue. The medical profession since World War II has done an almost unbelievably bad job of winning friends and influencing people. Notwithstanding the doctor-patient relationship which invariably is a warm one, the public generally became indifferent to the problems of a profession dealing with man's most precious commodity. It became a matter of loving the doctor but not the species.

As a result of public apathy (and in some cases hostility), doctors were a lonely group. When it came to fending off socialistic schemes like medicare and other intrusions by government they were pushovers for the bureaucrats.

Holding themselves aloof from community activities was only part

of the problem. In fact this aloofness should be accepted by most rational people willing to recognize that a doctor's schedule is the most inexorably demanding of any short of a battlefield. The argument would have stood on its own merits had not the profession with an almost traumatic determination set out to defeat it. Setting a weekday afternoon aside for a doctor's day off has plenty of basis in logic, but to the public the practice of all doctors taking the same afternoon off suggested a callousness and the notion that there might be a half day suspension of human suffering to accommodate the physician's leisure time activities.

Such an impression is, of course, nonsense. In Lafayette and South Bend, as in almost all America, a person in immediate need of a doctor's services can get those services immediately.

There were other misadventures in the area of public relations. Plagued by a shortage of their kind, doctors, necessarily for the most part needed to eliminate the house call, a practice that consumed wasted hours in travel. But an entire generation of old Americans had been brought up to regard the house call as a kind of birthright.

The same shortages in the profession required that appointments be made in advance, but "doctor can take you three weeks from Wednesday" uttered by a mechanized receptionist was small solace for the man who thought he had just caught leprosy at the company picnic. Moreover, because the time an individual patient will require with a doctor is unpredictable, waiting rooms would fill up with patients silently and nervously awaiting their turns. While the doctor in the inner office might be driving himself unmercifully, the receptionist's announcement "the doctor will see you now" represented a finality of condescension. Another blow was struck for socialized medicine.

An ethic which to the layman may

seem obtuse has long prevented doctors from improving their image for the public. This has to do with avoidance of personal professional publicity.

Almost every county medical society has at least one member whose skills at saving human life seem sometimes to be supernatural. Almost every successful doctor whose few hours of sleep are adorned with serenity knows that he has done something wonderful that day for another human being. Any nurse can tell you about the time she saw the courage and skill of a physician merge into a miracle.

It is not possible to report the continuing day-by-day stories of heroes in hospitals; if they could be told there would be massive arguments against the fiction that doctors are smug and self-serving. In the meantime, as more and more of them get out where the action is, doctors are winning back public opinion to the degree that the next time government intrudes into the private practice of medicine, there may be many, many more friends to help bar the way.

Public opinion can be a heartless taskmaster and there is something unfair about demanding extracurricular activity from those to whom we entrust our health. The irony is compounded when you consider how much of a man's life and substance is given away before he can even practice medicine. There is a certain sadness in the fact that society will not let him alone to concentrate on what Lloyd Douglas called "The Magnificent Obsession."—*Lafayette Journal and Courier*, May 6, 1967.

James Whitcomb Riley Hospital Is Enlarged

The James Whitcomb Riley Hospital for Children, known throughout Indiana for its service to children, soon will have a new face.

Ground-breaking ceremonies for a new \$7.7 million addition, which will extend across the front of the present

hospital, will be held at 11 a.m. Monday, June 19, at the Indiana University Medical Center in Indianapolis, it was announced today by Perry W. Lesh, president of the Riley Memorial Association, which supports the hospital, and Dr. Elvis J. Stahr president of Indiana University, which operates it.

The original hospital was built in 1924 with funds raised by the Riley Memorial Association in a statewide drive, a good share of it made up of nickels and dimes donated by school children. This will be the most ambitious expansion made to the hospital since that time.

Of the funds required for the present construction, nearly half (approximately \$3.5 million) will be provided from private gift funds appropriated by the board of governors of the Riley Memorial Association. Included is a gift from the Baxter Foundation of Indianapolis of \$800,000 for a Mothers' Pavilion in the Frances D. Baxter Memorial Wing of the addition.

The rest of the cost will be covered by grants made to Indiana University by the U.S. Public Health Service for special education and health professions teaching facilities in the new building.

The ground-breaking ceremonies will be held on the site of the Baxter Memorial Wing, one of three five-story wings to be built at this time. Long-range plans call for the construction of two additional wings, more than doubling the present patient capacity and providing the most modern pediatric facilities.—*Jeffersonville Evening News*, June 1, 1967.

A Response In Full Measure . . .

Among the dedicated citizenry responsible for the Mid-America University Fund Drive there never was a doubt of their success in meeting their \$750,000 goal. But the news that through their efforts a whopping \$826,200 has been raised is great news indeed.

And that is not all. The enlightened generosity of Tri-State residents, who know well the values of advanced education for their children and their children's children, will push the final total higher and higher.

The money will be used to acquire land for a 1200-acre Mid-America University Center west of Evansville for campus development. Indiana State University will begin the first phase of its Evansville campus construction later this year. Others will follow as certainly as it is certain that more and more high school graduates will enter colleges.

And even as drive leaders were accepting congratulations on a job well done, news just as welcome arrived from Washington—a federal grant of \$1,750,600 approved by the Office of Education to the Evansville branch of Indiana State to help construct a \$4,476,500 classroom and administration building in the university center.

Both news developments bespeak the confidence of area residents in their future and the confidence of Washington and Indiana in the area as it strives to meet the pressures of a burgeoning youth that year by year totals a higher percentage of the population.

Those pressures to extract a maximum potential for education offers a challenge and an opportunity for southern Indiana that the success of this fund drive helps to meet; and in meeting gains a singular opportunity for areawide cultural enrichment and economic advancement.

As Drive Chairman Robert L. Koch points out:

"This effort insures that land will be available for many years to come to meet our long-term needs in the development of higher education for southern Indiana. . . . However, we are not finished. There is a substantial amount of money which can yet be raised. . . . We will use the additional funds to develop and purchase more land. . . . This effort is entirely local—which emphasizes that Evansville is loaded with productive, re-

sourceful, energetic and unselfish people.

"Our success is attributable to hundreds of workers and donors who responded in full measure when asked to work for or give to the campaign."

The success of the drive also stands as a tribute to Tri-State business and professional people as well as many smaller donors from all walks of life, who realize that higher education is the soundest investment we can make in our area's economic growth. Inevitably every segment of community life will benefit.

And hopefully, in the years to come the Mid-America University Center will continue to expand to encompass a Southern Indiana Medical School and teaching hospital, a school of nursing, a graduate school of business administration, a school of pharmacy, vocational and technical training schools, a school of urban studies; yes, and others as of today not yet needed.

The success of this fund drive is another dynamic demonstration of the determination of Evansville folk to carve for themselves a key role in the mid-continent in the years ahead. —*Evansville Courier*, June 1, 1967.

A Double Obligation

Several months ago at a clinical convention, the House of Delegates of the American Medical Association urged physicians to consider the cost of drugs when prescribing medications for their patients. It was noted they should continue to have the freedom to prescribe either by brand name or generically, with medical consideration the primary factor.

However, it was pointed out that, "The physician also has an obligation to be mindful of the economic consequences of the treatment he prescribes." An official of the AMA suggested a procedure which would help each physician carry out these goals: Identify the 15 or 20 drugs he most often prescribes in his day-to-day practice; identify the brand, or brands, of each drug in which he

has confidence; have his medical assistant determine the price of each brand at local pharmacies, or obtain price information from drug retail men; when determining prices, learn if savings may be made by prescribing in quantities which are prepackaged by the manufacturer.

The action of the AMA went widely unnoticed as have countless other efforts of the medical profession in furthering the health and well-being of our people and in preserving and strengthening the doctor-patient relationship.—*Franklin Star*, March 29, 1967.

A Medical Center On Our Own

Handicapped by sectionalism our recent Indiana General Assembly failed to designate the site for a second Medical Center in this state but did try to establish a commission of specialists to decide upon a need for it and locate a site. It was designated the "blue ribbon" committee. But the bill establishing it was vetoed by Gov. Branigin because of the large fund appropriated in the bill for the use of the committee or commission which also might be confronted with sectional rivalry, as we have read. There is no doubt that INDIANA DOES NEED A SECOND MEDICAL CENTER AND THAT SOUTH BEND IS THE LOGICAL PLACE FOR IT.

We, therefore, throw into the hopper the suggestion that citizens of Michiana now pledge private funds to commence in or near South Bend this second medical establishment and that it be done with the understanding of similar cooperation from the University of Notre Dame and the I.U. Medical School as was proposed under legislative enactment. Such an institution initiated with private funds might well be called the Michiana Medical Center.

Such a privately established school could be assured of aid from the Federal Government and future Indiana general assemblies. In fact, not

being state owned should be a "feather in its cap."

An analysis will show that noteworthy achievements come from private initiative. There are many medical schools with "A" ratings which owe their existence to private initiative.

Whether supported by governmental or private money the cost comes from private sources. It is our belief that government is to regulate, not operate. It was by private initiative that our industries were developed until this area became known as "the workshop of America." It was on their own that talented doctors moved hither until this became a medical center of specialists. Similarly South Bend can be a center for instructing future doctors. The same hospitals would be available and we are not forgetting the new osteopathic one.

Private initiative endowed the quality of American communities like our own and built up this country. Private contribution like the one suggested here would return the investment.

We are solvent, we think, but usually hard-up for cash. *The Record* would pledge a contribution of some hundreds for an enterprise like this. We hope to have to pay it.—*South Bend Record*, March 17, 1967.

More Doctors

American physicians may not be able to meet the rising demand for their services during the next few years unless there is a marked increase in the productivity of medical manpower.

That is the central conclusion of a new Brookings Institution book. Entitled "The Doctor Shortage; An Economic Diagnosis," by Rashi Fein, it estimates that the demand for doctors' services will increase by at least 25% during the 1965-75 decade while the supply of doctors will increase by an estimated 19%.

To close the gap and to help raise the quality of medical care, the author

urges the consideration of a variety of steps to improve the productivity of medical manpower. Among the recommendations are the following:

Expansion of group practice so that new technology and new equipment can be used more effectively. (Group practice is also viewed as a way of encouraging the use of a personal or family physician while increasing the access to specialized care.)

Training of auxiliary personnel for physicians, following the lead of dentistry where the use of dental hygienists has markedly improved productivity. (A number of demonstration and experimental programs are now testing the usefulness of this step.)

Projections set forth in the study indicate that the total number of doctors will rise from 305,000 in 1965 to about 362,000 in 1975, in-

cluding foreign-trained graduates licensed to practice in the United States. Thus the ratio of doctors to population will rise from 156 to 161.

This means that changes in productivity will be needed to cope with changes in demand arising from such factors as the relative increase in the number of aged, the gains in education and income and Medicare.—*The Atlanta Constitution*. ◀

Letters

to the editor

Dear Doctor Ramsey:

The purpose of AMDOC is to send American physicians to areas of the earth where their skills and dedication are acutely needed and desired.

Whether it is a short term assignment in foreign medicine or a longer term affiliation, we are trying to serve the *AMERICAN DOCTOR*.

The AMA cooperates with us by referring Information Sheets for Overseas Employment to us for processing. The Michigan State Medical Society is sending us their International Health Service Information Forms.

We offer to you the same assistance. About 2,000 positions are to be filled by AMDOC and we do not have enough applications.

Such an assignment is really an education in medicine and great fun. It will interest you that the Educational Committee of the American Academy of General Practice has approved the thirty-day AMDOC program for educational credit. As you know, a member of the AAGP must get 150 hours of training every three years to remain a member. This in-

cludes fifty hours of Category I credit with a medical school and one hundred hours of Category II at medical meetings. By taking an AMDOC trip, a general practitioner can now obtain $33\frac{1}{3}$ hours of educational credit of his Category II requirement. In order to get this educational credit, one must go to school for two weeks. Now all one has to do is add another two weeks, go on an AMDOC trip and still get the credit.

Sincerely yours,
AMDOC, Inc.
(s) Dennis G. Karzag,
Executive Secretary

Dear Doctor Ramsey:

The case presented in the feature "The Cancer You View" in the May issue of *The Journal* is interesting and illustrates the alertness and aggressiveness with which possible malignant lesions should be approached for diagnosis and treatment.

Dr. Pontius is perfectly correct in his emphasis on early diagnostic study, but I believe there is an overemphasis on the need for hospitalization for such study. Probably 90% of the workup of a patient with the lesion he presented could be done outside the hospital.

Many physicians feel that unnecessary inpatient diagnostic workups contribute a significant segment of the overload now experienced by all hospitals, and that most of such studies could be done on the outside with considerable financial savings and the release of beds for therapeutic use.

I agree with Dr. Pontius' basic premise, that all lesions, and especially those which might be malignant, should be promptly and accurately diagnosed, but I think that as much of the study as possible should be done without taking up scarce beds.

Sincerely,
(s) John W. Beeler, M.D.
Indianapolis

Dear Doctor Ramsey:

After I read my *The Journal of the Indiana State Medical Association* I usually put it on the table in my waiting room and it eventually disappears. Not the May, 1967 issue; it goes into the sanctum sanctorum of my library. Please accept my compliments on such an important *Journal*.

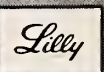
Sincerely yours,
(s) Goethe Link, M.D.
Indianapolis ◀

for
quick relief
that lasts
and lasts

Co-Pyronil[®]
Pyrrobutamine Compound



Additional information available to physicians upon request. ELI LILLY AND COMPANY, INDIANAPOLIS, INDIANA 46206.



700807

A report on the clinical use of a new diuretic agent with effective potassium retention. Profuse diuresis is obtained without hypokalemia and with few side effects such as leg cramps, weakness and postural hypotension.

Clinical Usefulness of the Diuretic Triamterene

JACK T. COLLINS, M.D.
Bluffton*

THE use of thiazide diuretics for treatment of congestive heart failure and many other states associated with edema has become standard practice. Although the benefits are many, the disturbing symptoms related to hypokalemia, a state often accompanying prolonged use of the drug, have pointed research efforts toward finding a diuretic free from this effect. Since aldosterone enhances sodium reabsorption at the distal renal tubule, its inhibition would lead to urinary sodium excretion and its concomitant sodium-potassium exchange would lead to potassium absorption and absence of hypokalemia. One drug, spironolactone, was found to be an effective aldosterone inhibitor; it is in common use today, and is frequently employed in combination with hydrochlorothiazide.

The present study was undertaken to extend the clinical experience with a new diuretic agent, triamterene. Although initially thought to have a similar action to spironolactone in its aldosterone-inhibiting effect, later studies showed its blockage of sodium

reabsorption at the renal tubule was independent of the aldosterone mechanism.¹⁻⁴ In the reports of Crosley et al.,⁵ patients receiving triamterene had a reduction in urinary potassium loss and there was no hypokalemia. As in the case of spironolactone, the addition of a thiazide increased the diuretic response.

Materials and Methods

Twenty-four patients were selected for clinical trial. Of this group, sixteen had congestive heart failure, three had Laennec's cirrhosis with ascites and five had miscellaneous clinical states associated with fluid retention. In addition to the initial history and physical examination, each patient had a complete blood count, two-hour postprandial blood glucose, BUN, serum calcium, electrocardiogram and PA chest film. Serum and urine electrolytes were determined in nine patients before and during triamterene therapy.

Since most of the patients in this study had been on diuretic therapy, little attempt was made to change the basic treatment program except for the addition of the new drug. Following the preliminary measurements

and a control period of one to two weeks on their basic program of salt restriction, digitalis and the use of a thiazide in most instances, triamterene was given in a dose of 50 mgm. three times a day.* Although the majority of the patients were initially in the hospital at the start of treatment, the drug was continued on an outpatient basis, with clinical visits every two to three weeks. The average duration of therapy for the entire group was 16 weeks, with a range of nine days to 15 months.

The assessment of drug effectiveness was based on the ability to control edema or reduce the signs of congestive heart failure.

All but four of the patients were managed by the author. Selected case reports will be included.

Three groups of patients were studied:

Group I — Congestive Heart Failure. Sixteen patients were included in this group. Seven had arteriosclerotic heart disease, seven had rheumatic heart disease, one had

* Kindly supplied by the Smith, Kline & French Company as 50 mg. capsules, SK&F #8542.

* From the Department of Internal Medicine, Caylor-Nickel Clinic, Bluffton 46714.

cardiomyopathy of unknown cause and one had amyloidosis, confirmed at autopsy. The clinical data are summarized in Table 1. The ages ranged from 18 to 26, with an average age of 58. All the patients presented with dyspnea as their main complaint. Five of the patients had had dyspnea for less than a month; the average duration of dyspnea for the entire group was 11 months. On the initial examination, signs of congestive

heart failure were detected in all patients, with edema present in 11 (61%); signs of pulmonary congestion without edema in four; ascites and edema in one and pleural effusion in one. All but four of the patients had been on treatment for congestive heart failure consisting of digitalis, thiazides and varying degrees of salt restriction. Because of the known benefits of these measures, combined with bed rest in the hos-

pital, triamterene was not started during the first five days of hospitalization.

Group II — Cirrhosis with ascites. Three male patients were included in this group. The average age was 54 years. Laennec's cirrhosis, moderately far advanced, was confirmed by liver biopsy. Hepatomegaly, ascites and edema were present in all three. Triamterene was given for periods ranging from three months

CONGESTIVE HEART FAILURE GROUP

Patient	Sex	Age	Type of Cardiac Disease	Duration of Cardiac Failure	Presenting Sign	Treatment Period	Other Diuretics	Clinical Response	
1.	G.B.	M	18	Rheu. Heart, AS, AI, MI, TI**	6 mo.	Anasarca	6 mo.	None	Excellent; edema cleared
2.	H.F.	M	41	Rheu. Heart, AS, fibrosis**	3 mo.	Pulm. rales	4 mo.	HC, AM*	Unchanged; dyspnea worse on triamterene
3.	D.H.	F	64	Rheu. Heart, MS**	2 mo.	Pulm. rales	9 days	None	Improved; dyspnea less
4.	M.P.	F	52	Rheu. Heart, MI**	12 mo.	Edema	10 days	None	Improved; less edema
5.	L.M.	M	53	Rheu. Heart, MI, AI**	3 mo.	Pulm. rales	5 wks.	None	Improved; dyspnea less
6.	C.O.	F	69	Rheu. Heart, MI**	5 yrs.	Anasarca	9 mo.	CT*	Edema cleared; dyspnea less
7.	U.B.	M	59	Rheu. Heart, MS, MI, AI**	6 mo.	Edema	2½ wks.	None	Unchanged
8.	D.N.	M	50	Amyloidosis (post-mort. biopsy)	4 mo.	Edema	10 days	None	Edema cleared
9.	B.S.	F	61	ASHD**	4 yrs.	Edema	12 wks.	None	Edema cleared
10.	F.B.	M	69	ASHD, Myocard.** Infarction, old	3 yrs.	Edema, massive	11 mo.	HC*	Edema considerably less; dyspnea less
11.	G.B.	M	67	ASHD**	1 mo.	Edema	3 wks.	C*	Edema cleared
12.	T.I.	M	76	ASHD**	1 mo.	Edema	10 wks.	None	Edema cleared
13.	T.S.	M	65	ASHD**	6 mo.	Edema	12 days	None	Edema cleared
14.	R.B.	M	60	ASHD**	1 wk.	Pleural effusion	2 wks.	C*	Effusion cleared
15.	H.H.	M	68	ASHD, Pulm. Embolus**	2 days	Pulm. rales	9 days	None	Lungs cleared
16.	J.C.	M	54	Cardiomyopathy, type unknown	3 mo.	Pulm. rales S3 gallop	8½ wks.	None	Lungs cleared; gallop still present

* Diuretic Abbreviations:

C = Chlorothiazide
 HC = Hydrochlorothiazide
 CT = Chlorthalidone
 AM = Aminophylline

**Cardiac Disease Abbreviations

AS — Aortic Stenosis
 AI — Aortic Insufficiency
 MI — Mitral Insufficiency
 TI — Tricuspid Insufficiency
 MS — Mitral Stenosis
 ASHD — Arteriosclerotic Heart Disease

TABLE 1

to four and one-half years. Clinical data for the group are presented in Table 2.

Group III — Metabolic edema and/or obesity. Five patients were selected for study. Two of these patients had had resistant or refractory obesity since childhood; the remaining three had edema of unknown cause, listed as metabolic edema.

Results

Group I — Congestive Heart Failure: All but two of the patients in this group improved while on therapy. The decrease in edema and body weight was accompanied by an improvement in the dyspnea. Most of the patients who received triamterene in the hospital were free of edema at the time of discharge; there was no reaccumulation of fluid during the outpatient visits. For the group as a whole, the diuretic response was not rapid when compared with a previous treatment period in which mercurials were given. Accompanying this less dramatic diuresis was a paucity of side effects such as leg cramps, weakness and postural hypotension, symptoms not infrequently encountered during the mercurial-thiazide treatment periods. Two patients complained of nausea. No other gastrointestinal symptoms were encountered.

Two patients failed to respond to triamterene therapy: the first was a 41-year-old white male with aortic

and mitral stenosis, marked myocardial fibrosis and left ventricular enlargement who had dyspnea and wheezing with minimal exertion. These symptoms did not worsen while on hydrochlorothiazide but did when triamterene was substituted, with nausea accompanying the drug ingestion. The second patient was a 59-year-old white male with severe congestive heart failure due to mitral insufficiency; no improvement was seen in the edema state while on triamterene. During therapy, the serum bilirubin rose from 2.2 mgm% to 3.4 mgm%. The serum potassium was 3.7 milliEq/L prior to therapy, with 7-8 day interval determinations being 5.4, 4.5 and 5.3 milliEq/L respectively. Intermittent somnolence occurred during this period, because the patient was receiving chlorthalidone at the same time, it was felt that the latter drug could have been responsible for this effect.

Two patients experienced a rather dramatic improvement of their edema state while on triamterene.

Case Report No. 1

Mrs. C. O., a 68-year-old white housewife with rheumatic aortic stenosis, mitral and tricuspid insufficiency, was seen initially at the Caylor-Nickel Clinic in October, 1962, for treatment of congestive heart failure of two years' duration. The initial examination revealed

cardiomegaly and atrial fibrillation, bilateral pleural effusions and a 4+ pitting edema of the legs. The patient was placed on a 2½ gm. sodium diet, digitalis, chlorthalidone (100-200 mgm/day) and intermittent mercurials. Although there was a clearing of most of her symptoms for two months, in January, 1963, anasarca reoccurred, accompanied by a return of dyspnea at rest. A mercurial injection would result in an eight pound weight loss of edema fluid, but this would be regained within a week.

In February, 1963, she was started on triamterene, 150 mg. daily; her chlorthalidone was continued. Two weeks following initiation of this therapy, her edema was moderately reduced and there was a 16 pound weight loss, despite the fact that no mercurial injections had been given. By the end of one month, her strength had improved markedly; her edema remained at only a trace. Her weight, which previously had been 128 pounds now stayed at 114 pounds. The blood urea nitrogen had peaked to 40 mgm% at the start of therapy but then dropped to an average of 23 mgs% thereafter. Multiple serum electrolyte determinations revealed no abnormalities. The highest serum potassium determination recorded was 5.1 mEq/L. No further mercurial injections were given.

In November, 1963, nine months

CIRRHOSIS OF THE LIVER

Patient	Sex	Age	Liver Biopsy	Duration	Symptom	Signs	Length of Therapy Response	
1.	J.B.	M	58	Laennec's cirrhosis	3 mo.	Dyspnea; abdominal swelling	Ascites; edema	3 mo. Improved
2.	R.B.	M	48	Laennec's cirrhosis	3 mo.	Edema	Edema	16 mo. Improved
3.	G.M.	M	56	Laennec's cirrhosis	4 yr.	Leg swelling; mental confusion	Edema; mental confusion	4½ yr. Improved

TABLE 2

after the initiation of triamterene therapy, the patient underwent a successful conversion of her atrial fibrillation to a normal sinus rhythm by the use of synchronized direct current shock. She maintained normal sinus rhythm thereafter. Despite her rather severe cardiac disease her edema was of mild degree, and she experienced improved ambulatory activity for a two and one-half year period.

Prolonged use of triamterene (over two years) in this patient demonstrated its acceptance to her. The marked decrease in the use of mercurial injections, as well as the improved ambulatory status, would appear to be reflections of the drug's usefulness. The use of chlorthalidone in the absence of triamterene was not effective in reducing the edema state. No side effects related to the drug were experienced by the patient. This case illustrates the value of using more than one diuretic in cases of refractory congestive heart failure.

Case Report No. 2

G. B., an 18-year-old white male with severe rheumatic heart disease manifested by marked insufficiency of the aortic, mitral and tricuspid valves, giant left atrium and chronic

atrial fibrillation, was admitted to the Caylor-Nickel Hospital in August, 1964, in severe heart failure. Anasarca and hepatojugular pulsations were present despite adequate digitalization, sodium restriction to under 500 mgs. per day, and the use of mercurial injections and chlorthalidone over a seven day period. No improvement in his congestive failure was seen, and he had to remain in a virtual sitting position because of severe dyspnea. Triamterene was then added to the treatment program, 200 mgs. per day during the first two weeks, then 150 mgs. daily thereafter. By the end of the second week, the patient experienced a 40-pound diuresis accompanied by marked clinical improvement. He was able to lie nearly flat in bed, his strength returned along with his appetite and he was dismissed from the hospital. The edema failed to reaccumulate during the three month period of triamterene therapy. No other diuretic agents were used during this period of time and no electrolyte abnormalities were present before or during the treatment.

The clinical improvement of this patient was unexpected. In the face of such severe valvular heart disease

and the absence of any clinical improvement with prolonged bed rest both at home and in the hospital, adequate digitalization and salt restriction, use of thiazide diuretics and mercurials, it was felt that the patient's nearly moribund state was irreversible. The effect of the triamterene was so marked that it appeared to be considerably out of proportion to the potentiating effect with other diuretic agents mentioned in other series.⁷⁻¹¹ Of further interest was the fact that despite the marked diuresis over a short period of time, the patient did not have any of the usual side effects such as weakness or muscular cramping.

Group II — Cirrhosis of the Liver: All three patients in this group responded well to triamterene. The first patient, J. B., a 58-year-old white male was admitted to the Caylor-Nickel Hospital in March, 1962, with dyspnea and anasarca of three months' duration. In addition to far advanced cirrhosis confirmed by biopsy, he also had ischemic heart disease with atrial fibrillation. Following removal of 13 liters of ascitic fluid, he was kept on a 200 mgm. sodium diet and chlorothiazide (0.5 mgm. twice daily). Twenty-four hour

EFFECT OF TRIAMTERENE ON URINARY SODIUM AND POTASSIUM EXCRETION IN THREE CIRRHOSIS PATIENTS*

Patient	Drugs**	Type Collection	24 hour Urine Vol. (ml.)	Ur*Na (mEq/24 hr.)	Ur*K (mEq/24 hr.)
G.M.	None	Control	3260	119	241
	Tr.** 150 mgm./day	6 months therapy	1570	109	182
		1 year therapy	1490	19	83
R.B.	None	Control	270	43	49
	Tr.** 150 mgm./day	4 months therapy	1600	24	108
	HC** 100 mgm./day	11 months therapy	3000	105	43
J.B.	None	Control	1220	.4	43
	Tr.** 150 mgm./day	1 month therapy	1560	10	163
	C** 1.0 mgm./day	2 months therapy	1680	1.3	52

**Diuretic abbreviations:
Tr. — Triamterene
HC — Hydrochlorothiazide
C — Chlorothiazide

* Patients hospitalized during control period and on sodium restriction (1000 mgm./day).
Ur — Urinary output

TABLE 3

METABOLIC EDEMA AND RESISTANT OBESITY

Patient	Sex	Age	Diagnosis	Duration of Edema	Length of Therapy	Associated Therapy	Response	
1.	R.T.	F	50	Marked obesity	2 yrs.	8 mo.	HC*	Fair
2.	E.F.	F	62	Marked obesity	3 yrs.	6 wks.	None	Fairly good
3.	M.N.	F	43	Metabolic edema	1 yr.	6 mo.	CT*	Very little
4.	K.L.	F	34	Metabolic edema	3 mo.	10 mo.	CT*	Fairly good
5.	D.T.	M	49	Hodgkin's disease with edema	2 mo.	5 mo.	None	Edema cleared

*See Table 1 for Diuretic Abbreviations

TABLE 4

sodium and potassium excretions were measured during chlorothiazide therapy and subsequently with the addition of triamterene, as illustrated in Table 3. Sodium excretion rose significantly, with a lesser degree of potassium excretion. During three months of ambulatory visits, the patient's weight remained stable and there was no reaccumulation of ascitic fluid.

The second patient, R.B., a 48-year-old white male with moderate leg edema, jaundice and ascites of three months duration, had liver biopsy characteristics of far-advanced cirrhosis. Esophageal varices were present on barium swallow. As in the first case, initial treatment in the hospital included a paracentesis, salt-restricted diet and the use of a thiazide diuretic and triamterene. Urinary electrolyte studies are listed in Table 3. The patient was rehabilitated from his bed-ridden state to ambulation and regular daily activities, although only mild degrees of physical exertion could be tolerated. His ascites did not reaccumulate even though the thiazide diuretic was stopped and the patient returned as an outpatient on triamterene alone. The serum bilirubin levels remained between 4 and 6 mgm%.

The third patient, G.M., a 56-year-old railroad office clerk with a four year history of ascites, was admitted

to the Caylor-Nickel Hospital in October, 1963. The initial findings included anasarca, hepatosplenomegaly and mental confusion with an abnormal electroencephalogram. The liver biopsy revealed far advanced cirrhosis; the serum bilirubin was 7.3 mgm%. Following baseline urinary electrolyte determinations, the patient was placed on triamterene, 150 mgm. daily, and maintained on a 1,000 mgm. sodium diet. By the end of the second week, his mental confusion had disappeared and there was a marked reduction in the edema. Following discharge from the hospital, he was able to resume work and was followed with monthly ambulatory visits. Five months after initiating triamterene therapy, the liver and spleen had reduced to normal size, the serum bilirubin had dropped to 2.5 mgm% and the serial urinary electrolytes were decreased in both sodium and potassium content. He has remained solely on triamterene for four and a half years without any side effects.

Group III — Metabolic Edema and Resistant Obesity: Five patients were included in this group, as summarized in Table 4. Two of the patients, E. F. and M.N., had marked resistant obesity, with weights of 250 lbs. and 410 lbs., respectively. Although edema was noted in the lower extremities at various times, accurate

assessment was not possible except for the general weight measurements.

E. F., a 62-year-old white woman, had maintained a weight of 250 lbs. for several years without benefit from standard weight-reducing programs. She was then hospitalized and placed on a six feeding-a-day diet employing 37 grams of carbohydrate daily. No weight reduction took place. Hydrochlorothiazide, 100 mgm/day was then added, without benefit. Despite a five-day period of fasting, her weight remained at 250 lbs. At this point, triamterene was started at a dose of 100 mgm. daily. During the ensuing 20 day period in the hospital, there was an 11 lb. weight loss. Weakness was noted by the patient. The serum potassium level was 4.3 mEq/L prior to triamterene, and 4.7 mEq/L on the 20th day of treatment. The serum sodium remained at 134 mEq/L, and the serum chloride rose from 85 to 99.6 mEq/L.

M. N., a 43-year-old white housewife, had had obesity since childhood, with a maximal weight of 510 lbs. (height 65 inches). In September, 1964, during a hospitalization for thrombophlebitis, she was placed on a six feeding-a-day diet with 37 gram carbohydrate, triiodothyronine, 100 mcgm. daily. Her initial weight was 400 lbs. She was then placed on triamterene 300 mgm. daily, with the dose reduced in one week to 150

mgm. daily because of weakness. After a three week period in the hospital, her weight had reduced to 367 lbs. Since discharge, the patient has taken triamterene for two month periods without showing any further weight decrease.

No definite conclusions could be made from these two cases. The addition of triamterene in the first case did appear to parallel the onset of her weight reduction, although other factors, such as the persistent carbohydrate restriction, were probably making themselves known at this time also. The second patient experienced more weight loss when on 300 mgm. of triamterene daily than 150 mgm., but she complained of weakness. This symptom cleared when she was on the lower dosage. Although she has not had additional weight reduction over a follow-up period of six months, her weight has not risen to its previous levels, indicating that she is responding to a limited degree.

The remaining three patients in the group had miscellaneous edema states, none of which were due to congestive heart failure or local stasis factors. Two of these patients were women who were thought to have edema related to their own endogenous progesterone. One of these women, Mrs. K. L., a 34-year-old housewife, complained principally of periodic swelling of her fingers, making it impossible to remove her wedding band. After voiding each morning, she weighed herself and kept a daily record for six months. Chlorthalidone 100 mgm. every other day did not keep her edema-free. With the addition of triamterene, the edema cleared and was paralleled by weight loss. The triamterene was stopped at two separately spaced monthly intervals, both of which were characterized by a return of the edema state. The last patient, D. T., a 48-year-old white male, had 3+ pitting edema of the legs related to Hodgkin's sarcoma. His edema was controlled with 150 mgm. triamterene daily.

Discussion

In 1962, Crosley et al.⁵ demonstrated the natriuretic effect of triamterene in their studies on 16 patients with various types of cardiovascular, renal and hepatic disease. Using a semiquantitative method for the detection of the drug in the urine, they established that 150 mgm. of the drug daily was an effective therapeutic dose. Maximal urinary sodium excretion occurred between the fifth and eighth hours after the oral ingestion of a single dose of triamterene. When given at a dose schedule of 50 mgm. three times daily over a 5-6 month period, they observed no significant change in the blood counts, liver function tests or serum uric acid levels.

Laufer et al.⁶ employed similar doses in the treatment of 35 patients with congestive heart failure. In many of the patients, hydrochlorothiazide, 25-50 mgm. daily, was added to the regimen, resulting in further natriuresis. No rise in urinary potassium was seen. Minimal elevations of the BUN were seen in five patients. Similar results were seen in a study by Wener, Schucher and Friedman¹¹ involving 30 patients with congestive heart failure. In Baba's¹ series of 42 edematous patients, good control of the edema state was achieved when triamterene was given on alternate days with a thiazide. The potentiating effect of triamterene when given with a thiazide has been well demonstrated by Liddle.⁷

This study confirms that triamterene is an effective diuretic agent when given to patients with congestive heart failure. Rather consistent improvement took place despite the fact that the majority of the patients were in an advanced stage of heart failure. Because of the known potentiating effect of triamterene when given with a thiazide, no attempt was made to change the patient's previous thiazide therapy. In the two case reports in this group, one patient did not require concomitant thiazide

therapy, while the other did. Except in the case of G. B., none of the patients showed a rapid weight loss such as usually occurs with injections of mercurials in the untreated state. In Crosley's studies,⁵ the weight loss was gradual, a finding somewhat similar to this study.

Perhaps the major benefit to be derived from the use of triamterene is its potassium-sparing action. In none of the patients studied was there any evidence of hypokalemia. The highest serum potassium recorded was 5.5 mEq/L. No serious side effects were noted with the long-term use of triamterene for periods extending up to four years. Two of the patients in the congestive failure group complained of weakness while on triamterene, in spite of the fact that the serum potassium levels were normal. These symptoms did not persist even though the drug was continued. One patient experienced some peculiar taste sensations.

Triamterene was well tolerated by the patients with cirrhosis, with no side effects noted. The concomitant use of other diuretics was not necessary in patient G.M. in this group. Serial urinary electrolyte determinations revealed a rise in urinary sodium excretion as much as four to ten-fold. There was generally a fall in urinary potassium. G. M. has remained on the drug four and one-half years to date, with serial bilirubin determinations in serum showing a gradual fall, although not to normal levels. The patient has remained full-time at his job.

BIBLIOGRAPHY

1. Baba, W. I., Tudhope, G. R., Wilson, G. M.: Triamterene, a New Diuretic Drug, *Brit. Med. J.* 2:756-764, 1962.
2. Ball, G. M., Greene, J. A.: Localization of the Site of Action of Triamterene Diuretic, *Proc. Soc. Exp. Biol. & Med.* (Ann Arbor) 113:326-328, 1963.
3. Baune, P., Radcliffe, F. J., Corry, J. R.: Triamterene—A New Natriuretic Agent, *Am. J. Med. Sci.* 245:668-675, 1963.

4. Cattell, W. R., Havard, C. W. H.: Diuretic Action of Triamterene in Man, *Brit. Med. J.* 2:1362-1366, 1962.
5. Crosley, A. P., Jr., Ronquillo, L. M., Strickland, W. H., Alexander, F.: Triamterene, A New Natriuretic Agent — Preliminary Observations in Man, *Ann. Intern. Med.* 56:241-251, (February), 1962.
6. Laufer, S. T., Mahabir, R. N.: Clinical Experience with a New Diuretic, Triamterene, in Congestive Heart Failure, *Canad. Med. Assn. J.* 91:315-318, August 15, 1964.
7. Liddle, G. W., et al.: Inhibition of Mineralo-corticoid Activity, *Metabolism* 10:1021-1030, November, 1961. (Specific and Non-specific Inhibition of Mineralo-corticoid Activity.)
8. Robertson, G. L., Dawson, J. W.: Primary Aldosteronism and the Effects of Two Mineralo-corticoid Inhibitors, Triamterene and Spironolactone, *Canad. Med. Assn. J.* 90:1170-1173, May 16, 1964.
9. Shaldon, S., Ryder, J. A.: Use of a Pteridine Diuretic (Triamterene) in Treatment of Hepatic Ascites, *Brit. Med. J.* 2:764-767, 1962.
10. Sperber, R. J., Fisch, S., DeGraff, A. C., Freudenthal, R. R.: Correction of Diuretic Induced Hypokalemia and Hyperuricemia, *Am. J. Med. Sci.* 249:269-272, March, 1965.
11. Wener, J., Schucher, R., Friedman, R.: Treatment of Congestive Heart Failure with Triamterene, *Canad. Med. Assn. J.* 92:452-460, February 27, 1965. ◀

About Our Cover

Few of the admirers of Sir Luke Fildes' work would recognize his name. But his best-known painting has been reproduced as widely—in schoolbooks, ads, postcards, on a stamp and in doctor's offices—as almost any in history.

Born at Liverpool, trained in the South Kensington and Royal Academy Schools, Sir Luke made many drawings on wood for *The London Graphic*, *Cornhill Magazine* and other periodicals and illustrated the last works of Dickens (*Edwin Drood*) and of Lever. He was also a member of England's Royal Academy and a painter of royalty, including Edward VII, Queen Alexandria and George V.

But his most famous painting was "The Doctor" which appears on this month's cover. Even before he began work on the painting in 1891, Sir Luke knew it would be a great success; "more terrible, perhaps, but yet more beautiful," than anything else he had done. "My idea, certainly, was to put on record the status of the doctor of our own time," he said.


A careful craftsman, he first built the cottage interior he intended to use in his London studio. The interior of the cottage was carefully planned and constructed, with rafters and walls and window — all as afterwards expressed in the finished picture. Copying that on canvas, and painting the dawn stealing in the prop window, Sir Luke inserted the characters he had in mind: worried parents hovering in the shadows, their sick little girl feverishly sleeping in the light of an oil lamp and the bearded doctor leaning over her, kindly and calm.

When he completed the picture, Sir Luke began all over again, only larger. The final version, which hangs in London's Tate Gallery, is still a great crowd-puller, but a less sentimental age no longer weeps openly at the sight of it, as visitors once did. The smaller first version is the proudest possession of the Guthrie Clinic in Sayre, Pennsylvania.

This month we salute the general practitioner who, like the physician on our cover, inspires and strengthens by his mere presence. Perhaps no other painting depicts so well the implicit faith all of us place in our physician.—J.F.S.

**Sick,
and
worried
sick**





Anxiety and tension stemming from organic illness may undermine your patient's cooperation and possibly retard success of primary therapy.

If his emotional symptoms persist in the face of your counsel and reassurance, you may want to consider adjunctive use of SERAX (oxazepam). It is indicated in anxiety, tension, agitation, irritability, and anxiety associated with depression. May be used in a broad range of patients, usually with considerable dosage flexibility.

When prescribing, carefully observe dosage recommendations and appropriate precautions, especially as pertaining to the elderly and when complications could ensue from a fall in blood pressure. (See Wyeth literature or PDR as well as "IN BRIEF" below.)

IN BRIEF.

Contraindications: History of previous hypersensitivity to oxazepam. Oxazepam is not indicated in psychoses.

Precautions: Hypotensive reactions are rare, but use with caution where complications could ensue from a fall in blood pressure, especially in the elderly. Withdrawal symptoms upon discontinuation have been noted in some patients exhibiting drug dependence through chronic overdose. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose; excessive, prolonged use in susceptible patients (alcoholics, ex-addicts, etc.) may result in dependence or habituation. Reduce dosage gradually after prolonged excessive dosage to avoid possible epileptiform seizures.

Withdrawal symptoms following abrupt discontinuance are similar to those seen with barbiturates. Caution patients against driving or operating machinery until absence of drowsiness or dizziness is ascertained. Warn patients of possible reduction in alcohol tolerance. Safety for use in pregnancy has not been established.

Not indicated in children under 6 years; absolute dosage for 6- to 12-year-olds not established.

Side Effects: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially; if persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leucopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

Availability: Capsules of 10, 15 and 30 mg. oxazepam.

To help you relieve anxiety and tension

Serax[®]
(oxazepam)



Wyeth Laboratories
Philadelphia, Pa.

This is the fourth in a series of articles describing the cancer program at Indiana University as supported by the American Cancer Society. The vital need for an effective therapy for the many different types of neoplastic diseases depends on progress made both at the bedside by the clinician and in the laboratory by the investigator. The advance in the fight against cancer is closely tied together with our understanding of the control of the functions of normal cells.

Cellular Development and Heredity

THE work of Dr. Tracy M. Sonneborn's laboratory,* supported by the American Cancer Society, deals primarily with certain aspects of cell heredity and cell differentiation, using the ciliated protozoan, *Paramecium aurelia*, as the experimental cell. As a result of 37 years of investigation by Sonneborn, his students and his coworkers, this organism is one of the genetically best understood and most flexibly utilizable unicellular organisms.

During the last seven years, one of the main topics under investigation in his laboratory has been the genetics of the structural pattern of the cell surface. Most of the microscopically visible



differentiations of this 125 x 40 micron cell are located in a surface layer about 1 micron thick. The basic unit of sur-

face structure is an internally open compartment about 1 micron square. Each of the thousands of such units on a *Paramecium* contains several structures: cilium, basal body, basal fibre, blind sac, membranous

vesicles, and so on. The various structures of a unit are precisely and asymmetrically organized. The units are furthermore organized into diverse surface fields and surface organelles, each precisely and definitely located in a highly asymmetric overall surface pattern. The precision and constancy of the detailed surface pattern present a remarkably favorable opportunity to explore its determination, to induce changes, and to analyze the fate of induced changes. The chief method adopted was in effect to graft surface parts in varying numbers and orientations. The grafts not only took, but grew and maintained their integrity and pattern indefinitely, being transmitted and reproduced through hundreds of asexual cell generations and dozens of sexual reproductions, as long as followed.

Surface Configuration

The basis of this inheritance was analyzed by cross-breeding, by nuclear substitution and by cytoplasmic substitution. The results showed unambiguously that the different hereditary surface patterns were not due to differences in genes, chromosomes, nuclei or their activities and not to the cytoplasm internal to the 1 micron thick cell cortex. They were due to the surface patterns themselves, each pattern determining its own perpetuation and reproduction. The details of how this happens are under

continuing investigation. Some components of the surface configuration have been shown to interact inductively in the determination and development of other components. The unit of surface structure mentioned in the preceding paragraphs has been shown in electron microscopic studies by Sonneborn's associate Dr. Ruth V. Dippell, to undergo growth and division, the new components of each unit arising in definite spatial relations to those in the parent unit. Hence, when a few units are grafted upside down, the daughter units they produce are also upside down.

This is the basis of Beisson and Sonneborn's finding that a stripe of abnormally oriented units in a graft develops and is transmitted upside down to all progeny, though surrounded by normally oriented rows of units. Dippell is currently investigating the mode of reproduction of the most conspicuous feature of each surface unit, the basal body or kinetosome, from which a cilium and certain internal fibres arise and around which all parts of the unit are precisely arranged. Special interest attaches to the basal body because of its similarity in ultrastructure to the centriole (which is also reproduced) and because of several reports that it contains DNA.

Genic Control Systems

Another major line of current investigation in Sonneborn's laboratory

* Department of Zoology, Indiana University, Bloomington, Ind. 47401.

concerns the mechanisms by which certain genic control systems bring about cellular and clonal differentiation. The system now at the focus of attention controls the "sex" or mating type of the cells. The most remarkable feature of this system is that cells of both mating types can have exactly the same set of genes, yet all asexual progeny of a single cell of either mating type inherit that mating type. Nevertheless, mutational studies have shown that nuclear genes code for the mating types. Hence, the hereditary difference between mating types is due not to what genes are present, but to which genes are activated or repressed. Gene repressions and activations are well-known in other organisms; in them the situation is reversible. The mating type system is the first one in which such genic controls are known to be hereditary and irreversible during asexual reproduction. In this respect they resemble certain cellular differentiations that regularly occur during the development of multicellular organisms. The nuclear differentiation involved in mating types occurs before the first cell division following sexual reproduction. Recently, others have discovered in other ciliated Protozoa similar asexually inherited nuclear differentiations arising at various later stages in clonal development, thus reinforcing the theoretical significance of this phenomenon for normal and perhaps abnormal development in multicellular organisms. Currently Sonneborn's group is engaged in a large scale attempt to dissect the genic components of the system by inducing mutations in it with the powerful new mutagen nitrosoguanidine, by characterizing the chemical effects of the mutations, and by attacking the mechanism of irreversible nuclear differentiation. A handle on the latter is provided by the fact that the agent which brings about the nuclear differentiation is a nuclear product that is also present in the

cytoplasm at the time of differentiation.

Origin of Viruses

The third project supported by the ACS concerns a theory of the origin of viruses. The problem arose in *P. aurelia* in the following way. Many years ago Sonneborn discovered that some paramecia (called by him killers) liberate into their medium a toxic agent which can kill other paramecia (sensitives). The hereditary basis of the killer trait is a bacterium-like particle carried in the cytoplasm of killer paramecia. There are many diverse kinds of killers, distinguished by the diverse pathologies of sensitives responding to their action. Here we are concerned with two kinds of killers: one carries a cytoplasmic particle called kappa; the other carries a different kind called mu. Kappa can be permanently maintained only in a paramecia possessing gene *K*; it is eventually destroyed irreversibly if the paramecia are homozygous for the allelic recessive gene *k*. The same situation exists for mu, except that different genes are involved, *M* and *m*. About a decade ago, one of Sonneborn's students, Chao, found that kappa does not disappear immediately after crosses that result in replacement of *K* by *k*. Later, Gibson and Beale in Edinburgh found the same for mu in relation to replacement of *M* by *m*. Both kappa and mu continue to multiply for about seven cell generations after the genic replacement, then some cells suddenly lose all their kappa or mu and more and more cells do so in the following cell generations until all or nearly all have done so by the 15th cell generation. Gibson and Beale interpreted such results to mean that a product of gene *K* (or *M*), which they called the metagon, was initially present in about 1,000 copies; that one copy was sufficient to maintain kappa or mu; but that after replacement of *K* or *M* by *k* or *m*, no more copies could be made, and the copies

present could not multiply, so their number per cell was progressively reduced by random distribution to progeny cells until cells arose that had none. Then the kappa or mu would be quickly destroyed.

The story took a sensational turn when Gibson came to work in Sonneborn's laboratory a few years ago. Sonneborn had just discovered that kappa could be put into species other than *Paramecium* and multiply in them, converting them into hereditary killers. Gibson and Sonneborn soon found that mu also could be made to multiply in these foreign organisms. They used mainly another ciliate called *Didinium*. This raised the question of whether *Didinium* had gene *M* or metagons. The metagon meanwhile had been reported by Gibson to be an RNA molecule, the "messenger" of gene *M*. In agreement, Gibson further reported that metagon RNA specifically was absorbed *in vitro* to DNA extracted from paramecia possessing gene *M*. Then he reported that it was not absorbed to DNA extracted from *didinia*. This seemed to eliminate the possibility that *didinia* had a gene like *M*. Gibson then claimed that *didinia* could maintain mu only when they possessed the metagon which they obtained by eating metagon-bearing paramecia; and that exposing *didinia* to RNase irreversibly destroyed their metagons and their capacity to maintain mu. Most exciting was his report that letting such a *Didinium* eat one metagon-bearing *Paramecium* was thereafter followed by hereditary presence of metagons in the *didinia*. In other words, it looked as if an RNA messenger of gene *M* in *Paramecium* became an RNA virus when introduced into a foreign cell.

The great theoretical significance of these claims led Sonneborn and his student Barbara McManamy to examine them independently after Gibson went back to Britain. Then the troubles began. McManamy found that kappa could grow in *didinia*

that by Gibson's criteria, contained no metagons. Using didinia that were metagon-free (by Gibson's criteria) she exposed them to purified metagon-free preparations of kappa and found that the didinia became hereditary kappa-bearers. Apparently no metagon was involved in this at all. She further found that sometimes all paramecia lost kappa and mu within a few cell generations after replacement of gene *K* or *M* by *k*

or *m*, respectively; sometimes all paramecia maintained them for 30 to 50 cell generations; and sometimes the kinetics of loss occurred in the way reported by Chao and by Gibson and Beale. Beale and Gibson then observed similar variations. Apparently the behavior of kappa and mu depended on more variables than had been recognized by Gibson. Several laboratories, including Sonneborn's, are engaged in trying to identify and

control the relevant variables.

Currently, Sonneborn's laboratory is working towards critical tests of an alternative hypothesis to account for all the observed phenomena, one based on the concept of genic control systems. Regardless of what mechanisms are revealed by further analysis of the problems, they probably should bear importantly on cell differentiation and heredity, if not on the origin of viruses. ◀

From *The Journal* 50 Years Ago

The patient is the son of a farmer and he says that 30 years ago while attending a horse for his father he contracted some disease in his nose which caused a bloody, watery discharge which he claims was not benefited by any treatment. He thinks he contracted this nasal trouble from having to wash the horse and later picking his nose. After some years there appeared on his arms and legs, copper colored spots which the doctors pronounced to be lues and they treated him for that disease.

A few years ago he was in Panama and slept in a certain room in a hotel for two and a half years where he was abundantly entertained during his wakeful moments by some very ferocious fleas and where his slumbers were disturbed by the machinations of a venerable old rat who was either remodeling the old hotel or building a new one in the attic above his bed. The patient says the fleas took their regular meals from him at night and got luncheon from the rat in the daytime. The patient at first stated that between the fleas and the rat, the disease had been carried to him from some low grade foreign workers. Later, from some of his remarks, it was impossible to determine whether he had not the same manifestations of disease that he now has, and that he believed the disease may have been carried by the fleas and rat to other workers in the neighborhood.

He was under the care of medical men of the army while there and later returned to the States and landed in a hospital in Indianapolis. Here an intern, fresh from his studies in the medical college and anxious to familiarize himself with all manner of germs, made and stained a smear of the discharge from the lesions. Finding the lepra bacillus, he reported to the authorities of the hospital and they confirmed the diagnosis. Then occurred a wild and romantic run.

If the news spread abroad before the patient got away from the hospital it would be impossible to get any carrier to take him to his home, and if left in the hospital it would mean the absolute ruin of the hospital patronage. The patient was speedily placed in an automobile and as speedily driven to Fort Branch and deposited at his home. The news spread rapidly and soon the business of the town was demoralized.

The United States government was appealed to in the hope that a mistake had been made, for the little town is powerless to move him from his present quarters and there is no place to take him if they could move him. The expert sent by the government confirmed the diagnosis, and the most rigid quarantine has been established. The little town must bear its burden till he dies or until Congress provides some means whereby he can be transported to some place where he can be taken care of without being a menace to commerce and a nuisance to the people.—S. L. Egart, M.D., Indianapolis, "Leprosy in Indiana—Report of a Case," *JISMA*, August, 1917.

Treatment of Arrhythmias Following Myocardial Infarction*

A. D. DENNISON, M.D.
WILLIAM R. STORER, M.D.
Indianapolis**

“TEN years ago the moon was an inspiration to poets and an opportunity for lovers. Ten years from now it will be just another airport.” So write Emmanuel G. Messthen. Ten years ago if someone had mentioned a coronary care unit we would have given an embarrassed and blank stare. Ten years from now it will be the accepted, smooth running, sophisticated part of an ever burgeoning and mushrooming scientific institution.

Twenty-five years ago a brave man in Boston dared to put a few sutures around a patent ductus arteriosus. Not many years after that I was projected out of medical school into a world where ultimately surgeons presume to enter any chamber of the heart. Many of us have had to either forget it or get with it. We had to learn the clinical profile of over 46 types of basic congenital heart disease, the language of cardiac hemodynamics, a new jargon of cardiac auscultation. It may be that the burden of perpetual education, years of training and esoteric problems are some of the reasons we find a drop in medical school applications.

Now we have been thrust into a new adventure—the intensive coronary care unit, the intelligent management of cardiac arrhythmias, the judicious steps in cardiac resuscitation,

and new thoughts in the total therapeutic program for the unfortunate individual with acute necrosis of the myocardium.

On a sunny morning, August 6, 1945, 120,000 people were killed by the A-bomb at Hiroshima. This is a shocking number, but each year coronary artery disease is the cause of death for more than 150,000 Americans less than 65 years of age. Can we as members of a massive humanitarian army neglect an understanding of the arrhythmic threats to these people?

Myocardial infarction represents an ideal state for the development of cardiac arrhythmias. Some of the contributory factors are: (a) myocardial injury; (b) anoxia due to impairment of coronary blood flow; (c) release of potassium from injured cells; (d) hemodynamic changes resulting from impaired myocardial contraction; and (e) increase in epinephrine and norepinephrine.

Arrhythmias in acute myocardial infarction are much higher than we previously thought. Spann and associates, Julian and co-workers, and Rothfield and colleagues have shown an incidence as high as 73%. Day's figures from an analysis obtained from new recording equipment indicated a computation of 71% with ventricular arrhythmias present in 60%. Thus we have three major enemies to combat in the recently assaulted heart—cardiac arrhythmias (including cardiac arrest), cardiac

decompensation and cardiogenic shock.

It is in the area of cardiac resuscitation and management of arrhythmias that modern developments permit the maximal impact on mortality, provided prompt recognition, intelligent and aggressive treatment are skillfully applied. Medical advances in the control of decompensation in this situation, and especially in cardiogenic shock, have been less dramatic.

Arrhythmias and Their Treatment

- A. Sinus Tachycardia:** Brief mention of persistent sinus tachycardia with a ventricular rate over 100 should be made as it has prognostic value. It often represents a grave prognostic sign. I have been struck through the years with its accuracy. The patient with a fast sinus rate often dies, for the elevated rate may reflect severe and extensive myocardial necrosis with associated shock and/or failure and/or fever, all secondary to the initial widespread pathology. The elevated rate may be due to overt or covert decompensation. But the decompensation is basically due to the quantitatively destroyed myocardial tissue. The mortality rate is generally twice that of the overall mortality.
- B. Atrial Arrhythmias:** At this point, a generalization may be made. Most arrhythmias occur-

*Talk presented by Dr. Dennison at the St. Mary's Hospital Symposium on Coronary Care, Evansville, June 9, 1956.

**From the Department of Internal Medicine, Methodist Hospital Graduate Medical Center, Indianapolis 45207.

ring during acute myocardial infarction are treated just as they are when infarction is not present. True, one may scale down dosage, true one may also be administering oxygen, true in some a vasopressor agent ensconced within 5% dextrose and water running intravenously is employed. Otherwise, the magic is basic. But how much less frightening the whole experience of managing these problems is now with a monitor-pacemaker and defibrillator close by.

1. *Atrial Premature Beats*—

Usually no treatment is required. If they are bothersome, sedation or quinidine may be helpful. When administering quinidine in one of its various forms—Cardioquin, sulfate, gluconate or Quinidex—observe the blood pressure rather closely. This drug is a myocardial depressant, may cause arterial hypotension with unfortunate and undesirable reduction in coronary blood flow.

2. *Atrial Fibrillation*—Some

years ago one of the faculty of Cornell Medical School, in an effort to simplify drug therapy of the various arrhythmias, made this statement: "Just remember that one drug, only one, is your first choice, your best agent, perhaps your safest agent, in the treatment of major atrial arrhythmias—atrial tachycardia, atrial flutter and atrial fibrillation. That is digitalis." The drug selected, the dosage employed, the route of administration are based on the urgency of the situation as determined by the clinical profile. Rapid rhythms jeopardize coronary perfusion and worsen the assaulted and insulted heart muscle's chance of recovery

—more damage, more likelihood of shock, more proneness to decompensation. Atrial fibrillation is frequently associated with atrial infarction. Usually it disappears as the infarction heals.

In general I like the rapidly excreted preparations in this situation—namely Cedilanid D or Lanoxin. One can come out of over-digitalization more quickly. As for dosage, again I recall an axiom promulgated by Dr. Harry Godd, also of Cornell. He recommended a 10% reduction in the total digitalizing dosage in the patient with myocardial infarction who might need digitalis. We must realize that the ischemic and infarcted myocardium demonstrates increased sensitivity to digitalis medication. Also, it increases the sensitivity of the carotid sinus.

I can see a definite place for quinidine in the prevention of recurrences. Yet as to its use in the treatment of these three major atrial arrhythmias, I can envision little need. Our major concern is to slow the cardiac rate and support the myocardium.

One makes such a statement with respect for antiquity and the distinguished Dutch cardiologist, Wenckebach. It was in 1912 that Dr. Wenckebach was told by a patient, a merchant from the Dutch East Indies, that when he took quinine as a general tonic, he had less trouble with auricular fibrillation than at other times. The patient was able to demonstrate this to Wenckebach's satisfaction. Later, Wenckebach and Frey investigated the effect of the

various salts derived from the cinchona bark on the heart and found that quinidine sulfate was the most valuable in converting atrial fibrillation into normal rhythm. I might add an interesting historical note about Dr. Wenckebach. On examining a patient one day, he became intensely interested by discovering a peculiar cardiac arrhythmia. He remained bent over the patient listening intently for such a long time that the patient thought Dr. Wenckebach had fallen asleep. Would that in this mad, frenzied, frantic, frenetic pace at which we practice medicine, there were enough time to examine just one patient thoroughly and properly.

3. *Supraventricular Tachycardia*: This is seldom associated with acute myocardial infarction. In Hughes W.

Day's continued tape recordings of 56 subjects with acute myocardial infarction, he observed only two cases of this rhythm disturbance. In this group there was one case of atrial flutter and nine of atrial fibrillation. This corresponds well with the experience of others. Less than two months ago, one of our keen interns was called to see a female patient of mine on the Intensive Care Unit. She had slipped into a rapid rhythm disturbance. By monitor and by direct writing EKG, also doubling the paper speed and voltage in V-1, it proved to be a supraventricular tachycardia. When he reported this by phone, I recalled its rarity in the infarcted myocardium, conjured up in my mind an atrial infarction, until he ex-

ploded the balloon by gleaning from her that she had been having similar experiences down through the years. She was not a case of the Wolff-Parkinson-White syndrome or the Levine-Ganong-Lown syndrome—reported more commonly in the female. An injection of Demerol terminated her alorhythmia promptly. She was not digitalized.

4. *Atrial Flutter*: This too is rarely associated with acute myocardial infarction, usually occurs in the presence of pre-existing organic heart disease and rapid digitalization is the method of choice. Embolism is a rare complication of atrial flutter. Once the ventricular rate has been controlled by digitalis and spontaneous reversion to normal sinus rhythm fails to occur, quinidine may be used.

C. **Ventricular Arrhythmias:**

Next we move into an area of danger for the doctor and the patient. These should be treated with concern and respect. Ventricular arrhythmias were observed in 60% of Day's 56 cases on the continuous tape.

1. *Ventricular premature beats*:

The occasional occurrence of ventricular premature beats is well tolerated by patients with myocardial infarction. But over six per minute requires suppressive therapy. One can use Dilantin, quinidine or procaine amide (Pronestyl). Dilantin has been found to reduce ventricular ectopic activity following acute myocardial injury caused by coronary artery ligation (Bellet). It is not strongly anti-arrhythmic but can be employed in mild situations. The next drug of choice is quinidine. I have

preferred Cardioquin (quinidine polygalacturonate) because it creates less gastrointestinal irritation. Finally, for one who cannot tolerate quinidine, Pronestyl is available. The dosage is 250-500 mgms. four times a day. One of our former Indianapolis cardiologists showered ventricular premature beats in the immediate post-infarction period and could not tolerate quinidine. Pronestyl was virtually life-saving and was required for many months.

The significance of ventricular ectopic beats is that such stimulation of the ventricles may occur early in diastole, in the so-called vulnerable period of the ventricle. It may eventually cause ventricular paroxysmal tachycardia and seconds after—the frightening ventricular fibrillation. In electrocardiographic language we are referring to a ventricular ectopic beat that fires off on the peak or downstroke of the preceding T wave. Observation of this pattern requires immediate therapeutic attention. Bigeminal rhythm also carries ominous import.

2. *Ventricular Paroxysmal Tachycardia*:

The serious nature of such a rhythm has been adequately documented. Cardiac rate alone is not entirely responsible for the complete deterioration of blood pressure and cardiac output. In Day's study, ventricular tachycardia was preceded by ventricular bigeminy in 55% of the cases documented as having this serious disturbance of rhythm. In comparison however with the large number of patients seen with coronary heart disease, the pro-

portion of cases of ventricular tachycardia is relatively small. It is always a serious complication and usually occurs in the presence of a massive infarction and in association with shock.

Why is it benign in one case—without terrific drop in blood pressure and cardiac output; then malignant in another, requiring immediate attention and vasopressor drugs? It has been theorized by Corday that the reason for the marked variation in hemodynamics might lie in the different location of the ectopic focus. If the focus is near the base of the heart, the blood will first be propelled toward the apex and then be shuttled back into the outflow tract. This is inefficient and it has been postulated that the outflow tract may be constricted by the time the blood is shuttled back into it and this throttles the cardiac output. The benign type originates near the apex and the hemodynamics are little disturbed except for the rapid rate when the heart will have inadequate time to fill. There is no doubt that one sees these two different types of ventricular paroxysmal tachycardia—benign and malignant. One allows a little time for reflection and planning. The other demands immediate heroic therapeutic action.

Therapeutic Steps

- A. The arterial pressure should be maintained, when necessary, by vasopressors—Aramine, Levophed or Isuprel. If an infusion has not been running, one should be started immediately as many uses may be made of this indwelling intravenous need-

le. The restoration of systemic pressure often converts ventricular tachycardia. But the blood pressure must be carefully monitored and controlled when these vasopressor drugs are dripped intravenously, because extremely high pressure levels can induce ventricular fibrillation. From 40-60% of paroxysms of ventricular paroxysmal tachycardia convert spontaneously when the systemic pressure is restored. Presumably, this is brought about through better coronary artery perfusion and lessening of myocardial ischemia and irritability.

- B. *Lidocaine* (*Xylocaine*®): This is greatly in vogue. The drug should be in every critical area of the hospital, especially the coronary care unit. It is recommended first over procaine amide chiefly because it does not produce the marked hypotension

which commonly follows the intravenous administration of the latter agent. It is less depressing to the myocardium with relatively much less depression and slowing of the S.A. node. The peak blood levels decrease rapidly. One-hundred mgm. may be given intravenously and be repeated at 15 to 20 minute intervals. The maximum total dose has not been firmly established in large numbers of patients, but 500 mgm. has been administered in one hour without toxic effects. Again, electrocardiographic monitoring is mandatory.

- C. *Procaine Amide I.V.*: 50 to 200 mgms. per minute up to a total of two gms. may be necessary. Again, monitoring the EKG pattern and the blood pressure are a necessity.

Some of the most frightening experiences of my cardiologic career have been in the management of this dangerous and prognostically unsafe allorhythmia. I recall

one man with the benign type, in association with coronary heart disease, who remained in this unfortunate rhythm for 12 days. He finally reverted to NSR on the fifth day of the Sokolow regime of quinidine sulfate every two hours for five doses, increasing the individual dosage each day.

- D. *Quinidine*: Restores normal rhythm when administered orally, intramuscularly or intravenously. The latter route is rarely employed.
- E. *D.C. Countershock Cardioversion*: Usually the rhythm converts instantly to sinus rhythm after an initial shock of 200 to 400 watt seconds or joules. It is important, however, to administer procaine amide or quinidine before the electric countershock in order to prevent the recurrence of ventricular tachycardia.

Ventricular fibrillation, ventricular standstill and various degrees of A-V block will be the subject of a future communication. ◀

® Registered U.S. Trademark of Astra Pharmaceutical Products, Inc., Worcester, Mass.

INDIANA MEDICAL BUREAU

816 Hume Mansur Bldg.

634-5804

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 16th Year Of Service

Intensive Coronary Care Units

WILLIAM R. STORER, M.D.
Indianapolis*

Reduction in Mortality

The need for coronary care units has been well documented in theory and in practice. It is apparent that the least mortality and morbidity from coronary heart disease will result from prevention of the disease. However, it is well known that the cause of atherosclerosis is not well established, much less an effective plan for its prevention. Therefore, we must be content for now to treat the disease after it presents. Meltzer has pointed out that in the last eight years, the fatality rate from myocardial infarction has been 21% to 26%. When broken down more specifically, the deaths have been due to arrhythmias 47% of the time, shock or heart failure 43% of the time, emboli eight percent and other causes have contributed only two percent of the deaths.⁸ Furthermore, it has been shown that 69% of the arrhythmias occurred in the first 72 hours, and 64% of the shock and congestive heart failure occurred in the first three days. Eighty percent of the emboli, on the other hand, occurred after the first three days. It is encouraging to note that the most treatable catastrophies, the arrhythmias, shock, and congestive heart failure, occur early and are now causing the greatest number of deaths.⁹

Cardiac catastrophies, including ventricular fibrillation and ventricular standstill, can often be successfully treated if the treatment is instituted within the first one to two minutes. It is therefore necessary to monitor the patient continually and to have an alarm system which would be activated in the event of the catastrophe. Treatment facilities also

must be very close at hand for the treatment to be instituted in the first two minutes. The only way to accomplish this effectively is in a coronary care unit.⁸ Zoll has pointed out that monitors are not only useful for rapid treatment of the catastrophe but also for recording data for research purposes.¹¹ It has been estimated that 45,000 patients a year could be saved in America with ready availability of coronary care units.²

The system of coronary care is fairly simple in principle. The patient is admitted directly to the coronary care unit when the diagnosis of acute myocardial infarction is made or suspected. Here the electronic equipment and specially trained personnel are centralized. The patient is constantly monitored for rate and rhythm, and the nurse is in constant attendance. When a catastrophe occurs, the nurse is trained to recognize it. In the event that a doctor cannot arrive in time, such as when cardiac arrest occurs, the nurse is qualified to institute treatment such as defibrillation and pacemaking as well as external cardiac massage and ventilation. If the problem can wait for the doctor, the nurse calls him, and while awaiting his arrival, she prepares the drugs and equipment that she anticipates the doctor will need.

Qualified Staff Essential

The quality of care demands a highly trained staff. The staff of a coronary care unit includes a director who oversees the unit's function and makes basic policy for the unit. The attending physician is an integral part of the staff of the unit in that he directs the specialized care of his

SINCE man discovered that some cardiac emergencies could be reversed, there has been a vigorous search for methods of better applying resuscitation procedures. Dr. Hughes W. Day proposed a plan for development of an organized program for emergency treatment of the cardiac catastrophe. His plan contained three phases, the first being a program to recognize and treat cardiac arrest and ventricular fibrillation in the operating room and post-anesthesia recovery room. The second phase which he instituted was the organization of a team to treat the cardiac emergency on the floors of the hospital. The team included a nurse, usually the floor nurse, an inhalation therapist, an anesthesiologist and a physician, usually the one closest at the time of the catastrophe. The equipment used was kept on a crash cart in the emergency room.

The plan was called the Code Blue Plan because the color of the patient involved was most often blue. The telephone operator paged "code blue" to activate the team in the event of an emergency. Dr. Day found this plan to be quite effective but cumbersome and time-consuming. He reasoned that the patient most likely to have a ventricular catastrophe was the heart attack patient. It seemed that if the myocardial infarction patients and the electronic equipment were concentrated in the same area, many of the emergencies could be more quickly and adequately treated. Dr. Day organized the first well publicized coronary care unit.¹

* From the Department of Internal Medicine, Methodist Hospital Graduate Medical Center, Indianapolis 46207.

patient. House staff, if available, helps a coronary care unit function more efficiently because of ready availability. The nurse is the key to the entire program.¹⁰ The nurse's role, in addition to the routine nursing duties she is accustomed to, involves identification of major cardiac problems when they arise, treatment of these problems when they demand immediate attention, and having treatment tools ready in anticipation of the doctor's needs.⁸ It is obvious that the nurse must be trained in several highly specialized areas, especially electrocardiography. Dr. Day has summarized the importance of the nurses to good coronary care by stating that the "... unit will only be as valuable as the staff of nurses you have in the area, their abundance, training and quality."³

The selection of patients was originally thought to be a difficult problem. It was thought that only the patients with complications of myocardial infarction need intensive care. However, Zoll has pointed out that the value of monitoring and the prompt application of resuscitation is especially essential for "those patients who are doing rather well and who have not suffered major myocardial damage and loss of muscle, but who may die as a result of a fatal arrhythmia."¹¹ Imboden stated that "Cardiac arrest and lethal arrhythmias occur at least as frequently in the so-called mild case as in the severe case, and perhaps, more often."⁷

There have been few major problems encountered in coronary care unit operation. False alarms are constantly a problem, and these are usually caused by electrode placement technic.⁶ The other problem associated with electrodes is the dermatitis that occurs, either as a reaction to the tape, electrode paste or electrodes themselves. No adequate answers to these problems have as yet been found.^{2,4} Visitors create another problem because of their anxiety and the lack of space. This has generally been solved by situating the waiting room at a distance from the coronary care unit and limiting visiting time.⁴ Many worried about the patient's psychologic response to the electronic equipment, but in general the patients seem to enjoy the sense of security they receive from this specialized attention. In fact, often they are apprehensive upon transfer from the unit.⁴

The only results being published from coronary care units are from Dr. Meltzer's unit in Philadelphia and Dr. Day's unit in Kansas City. Dr. Meltzer's first report revealed 19 cases of ventricular tachycardia; 16 of these converted spontaneously or with drugs, and three were terminated with countershock. There were no fatalities. Six patients encountered ventricular fibrillation, and all were successfully resuscitated with countershock. There were four episodes of cardiac arrest; two of these were resuscitated, and two died.⁹ He reports that in the first 200 patients treated in his unit, mortality was decreased 30% over a control group

treated in other sections of the hospital.⁸ Dr. Day reports the treatment of 336 patients in the first four years of operation of the coronary care unit at Bethany Hospital in Kansas City. The mortality among these patients was 21% while the mortality among patients treated on the general medical floors during the same period was 34%. The successful resuscitation rate was 58% (patients successfully resuscitated from ventricular fibrillation or ventricular standstill).⁵

BIBLIOGRAPHY

1. Day, H. A.: Cardiac Resuscitation Program, *Lancet* 82:153-156, April, 1962.
2. Day, H.: An Intensive Coronary Care Area, *Dis. of the Chest* 44:423-7, Oct., 1963.
3. Day, H.: The Efficiency of an Intensive Coronary Care Unit, *Acad. of Med. of New Jersey* 10:312-315, 1964.
4. Day, H.: Preliminary Studies of an Acute Coronary Care Area, *Lancet* 83:53, 1963.
5. Day, H.: Four Year Results from the Hartford Coronary Care Unit, unpublished.
6. Harris, R.: Laying the Right Lines for Electronic Monitoring, *Nursing Outlook* 11:573-576, August, 1963.
7. Imboden, C.: Coronary Care Units, *Med. Anns. of the Dist. of Col.* 33: 442-444, 1964.
8. Meltzer, L.: Coronary Care Units Can Help Decrease Deaths, *Modern Hospital* 104:102-104, January, 1965.
9. Meltzer, L.: Concept and System for Intensive Coronary Care, *Acad. of Med. of New Jersey* 10:304-311, 1964.
10. Meltzer, L.: *Intensive Coronary Care, a Manual for Nurses*, Coronary Care Unit Fund, 1965.
11. Zoll, P.: The Cardiac Monitoring System, *JAMA* 186:34-36, November 2, 1963.

Authoritative recommendations for the treatment of pulmonary tuberculosis in active, quiescent and inactive forms, and in recent converters.

Tuberculosis Treatment and Follow-up

JOHN D. MILLER, M.D.
Indianapolis*

CERTAIN methods of management for patients with pulmonary tuberculosis and for those exposed to tuberculosis have been formulated but this information is not readily available in convenient form. This outline will attempt to formalize these recommendations and document the practices of the Pulmonary Disease Clinic of Marion County General Hospital. Most are closely adherent to the statements, policies and findings of the American Thoracic Society, the American College of Chest Physicians, and the cooperative studies of the Veterans Administration-Armed Forces and the United States Public Health Service. For more exhaustive discussions, reference to these sources is highly recommended.

Standards for reporting of cases to local health authorities are quoted

* Clinical Director, Pulmonary Disease Service, Marion County General Hospital, Indianapolis 46207. Also Instructor, Department of Medicine, I.U. School of Medicine.

from directives of the Indiana State Board of Health.¹ Disease nomenclature used is from the "Diagnostic Standards and Classification of Tuberculosis" of the National Tuberculosis Association, 1961.

Patients who must be reported to local health departments are:

1. All active cases of tuberculosis including:
 - a) Diagnosed cases with tubercle bacilli demonstrated (including all forms; pulmonary and extra-pulmonary, both primary and reinfection tuberculosis).
 - b) Cases diagnosed by a physician on roentgenographic, histological, or clinical evidence consistent with active tuberculosis but without bacteriologic confirmation (including all forms; pulmonary and extra-pulmonary, both primary and reinfection tu-

berculosis).

- c) Unexplained pleurisy with effusion.
2. Certain cases not considered as active such as:
 - a) Diagnosed quiescent pulmonary cases.
 - b) Diagnosed inactive pulmonary cases.
 - c) Diagnosed cases with activity undetermined or not reported.
 - d) Recent tuberculin converters with no roentgenographic or laboratory evidence of tuberculous involvement.
 - e) Tuberculin reactors under age five (5).

Patients in both categories 1 and 2 must be reported.

The State Board of Health has requested that the following cases be reported for program development:

1. Tuberculosis suspects.
2. Healed primary calcifications, single or multiple, including healed primary tuberculosis.
3. Healed extra-pulmonary tuberculosis.

Reports must be made to the local health department within 24 hours after diagnosis. Forms for such reporting are available from the Indiana State Board of Health.

Treatment

Specific treatment for tuberculosis by effective drugs has been available since 1946. The following is a listing of the more commonly used drugs with usual adult doses.

DRUG	ROUTE OF ADMINISTRATION	USUAL ADULT DOSE	TOXICITY
Isoniazid (INH)	Oral	3-5 Mg/Kg or 300 Mg. daily	1. Unusual 2. Peripheral neuritis 3. Psychosis
Streptomycin	Parenteral	1 Gm. daily or 1 Gm. twice weekly	1. Moderate 2. VIII nerve 3. Renal
Para-amino-salicylic acid (PAS)	Oral	8-12 Gm. daily	1. Drug fever 2. Moderate 3. Gastro-intestinal 3. Hepatic

Other drugs available are accompanied by greater toxicity and are less commonly used. Pyrazinamide, Cycloserine, Viomycin and Ethionamide form this second group. Toxicity of this second group of drugs usually precludes outpatient use.

Bacterial resistance develops to all of these drugs and is occasionally seen in a previously untreated tuberculous infection. Study of the sputum bacteriology is therefore essential for the proper management of tuberculous patients. Because of the pro-

pensity for the development of bacterial resistance, single drug therapy is used in only a few instances. Double or triple drug therapy delays the emergence of drug resistant bacilli. Drug treatment must be continued for 18 to 24 months or longer.

Sputum examinations may be obtained at the Indiana State Board of Health laboratory. Sputum examinations should be done initially and no less often than every two months during the active phase of the patient's disease. Sputum examinations

should be done at six month intervals following attainment of inactivity or quiescence.

Examinations of gastric washings of outpatients are usually non-informative. Inhalation aerosol induction of sputum may prove useful. Patients having obstructive bronchial disease may react unfavorably to hypertonic saline aerosol sputum induction.

The following is a tabulation of different disease situations with the usual medication and follow-up procedures.

PATIENT	MEDICATION	FOLLOW-UP
A. Diagnosed cases (including all forms).		
1. Active, probably active, activity not determined.	Double drug therapy mandatory. Regimen individualized for each patient. Isoniazid with a companion drug is the regimen of choice. Resistance studies of organisms should guide selection of drug and therapy. Toxicity to drugs usually demonstrated within the first 3-4 months. Drug therapy 18-24 months minimum.	No less frequent than every 3-4 months. Most usually every 4-8 weeks initially. Chest x-rays recommended for proper evaluation. Isolation necessary until tuberculosis is non-contagious. (Three consecutive culture negative monthly sputums.) Reduced activity recommended. Complete bed rest no longer deemed necessary.
2. Quiescent	Double drug therapy advisable. Regimen should contain Isoniazid with companion drug. After long term double therapy of three years or more, single drug therapy with INH may be considered.	No less frequent than every six months. Usually every 3-4 months. Chest x-ray and sputum examinations recommended for proper management. Disease reactivation is frequent. Activity status-work tolerance for light to medium activity usual. Occupations involving close contact with children not advisable. Lifetime follow-up recommended.
3. Inactive, probably inactive.	Double drug therapy with INH continued for one year after attainment of inactivity. Single drug therapy with Isoniazid frequently continued two to three years more.	No less frequent than every six months. Sputum examination and chest x-ray should be obtained every six months. Activity status not usually restricted. No occupational limitations. Lifetime follow-up recommended.

PATIENT	MEDICATION	FOLLOW-UP
B. Recent converters* to Intermediate PPD Mantoux.# (Conversion within 12 months at any age.) This is a "high risk group."	Children: Isoniazid 5-10 Mg/Kg daily for one year. Adults: Isoniazid 3-5 Mg/Kg daily for one year.	No less frequent than every four months. Usually every 4-8 weeks during initial phase. After drug treatment, every six months for five years. Then once yearly. No isolation or restriction of activity usually indicated. Lifetime follow-up recommended.
C. Reactors* under age 5 to Intermediate PPD Mantoux.# This is a "high risk group."	Isoniazid 5-10 Mg/Kg.	Initially every 4-8 weeks. No less frequent than every four months. After drug treatment, every six months for five years. Then once yearly for life. No isolation is usually required. Reduction of activity usually not required but is advisable if child is symptomatic. Lifetime follow-up recommended.
D. All other skin test reactors (5 millimeters or more of skin induration to Intermediate PPD Mantoux).		
1) Six to twenty millimeters skin induration.	NONE	At least once yearly for life. Chest x-ray at time of yearly physical examination is advisable.
2) Twenty millimeters or more skin induration to Intermediate PPD Mantoux. This group is a "high risk group."	Isoniazid 3-5 Mg/Kg or 300 mg. daily for an adult for one year.	No less frequent than every six months. Every 3-4 months usual during medication. Isolation and activity reduction not necessary. Lifetime follow-up recommended.
E. Patient with a chronic debilitating disease (chronic obstructive lung disease, diabetes mellitus, postgastric resection, long term steroid medication) with positive tuberculin reaction to Intermediate PPD Mantoux. (More than 5 millimeters induration.)	Isoniazid 3-5 Mg/Kg 300 mg. daily for an adult for one year.	No less frequent than every six months. Usual follow-up every 3-4 months during treatment. Lifetime follow-up recommended.

* A positive reaction is defined as induration of 5 millimeters or more measured at right angles to the long axis of the arm. Since the Mantoux test done with Purified Protein Derivative (PPD) was used in the clinical trials upon which this outline is based, the recommendations as outlined here refer only to this test. Other methods of skin testing using different antigenic materials have not been as extensively studied in clinical field trials. Retesting of reactors to other tuberculin tests with an Intermediate PPD Mantoux test is recommended.

#0.1 cc. commercial Intermediate PPD solution containing five tuberculin units or 0.0001 mg/0.1 cc. injected intradermally.

For further details you are urged to contact your local tuberculosis treatment facility, your local tuberculosis association or current literature.

REFERENCES

1. The Indiana State Board of Health, *Technical Bulletin*, August 15, 1965.
2. National Tuberculosis Association—

Diagnostic Standards and Classification of Tuberculosis, 1961.

3. American Thoracic Society Committee—Treatment of Tuberculosis in Children, *Am. Rev. Resp. Dis.* 81:446, 1960.
4. American Thoracic Society Committee—Treatment of the Adult Tuberculin Converter, *Am. Rev. Resp. Dis.* 81:443, 1960.
5. American Thoracic Society Com-

mittee—Preventative Treatment in Tuberculosis, *Am. Rev. Resp. Dis.* 91:297, 1965.

6. American Thoracic Society Committee—The Use of Chemotherapy as a Public Health Measure in Tuberculosis, *Am. Rev. Resp. Dis.* 84:609, 1961.
7. American Thoracic Society Committee—Rest, Exercise and Work in the Treatment of Tuberculosis, *Am. Rev. Resp. Dis.* 84:613, 1961. ◀

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 9-12, Indianapolis, Indiana.

I propose to exhibit_____

Name_____

Address_____

City_____

State_____



The Case of Iatrogenic Idiopathy

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

THE plodding practitioner would convert to a prudish pedant were he to start with the ityphallic inserts of the parent. But the doctors were unaware of these iterative pudendal probes that had conditioned the very core of this patient's psyche. The "battered child syndrome" can be mental as well as crassly physical. History taking is not always routine: it can take the patience of a Buddha and demand the perceptive powers of a Sherlock Holmes. We can all learn as we retrace the efforts involved in peeling off the enshrouding, cocoon-like layers concealing the crux of the case.

At governmental chronic care facilities, turnover of patients AND personnel is minimal. Case #1, admitted when the hospital first opened, may still be there 25 years later. When I first "went on service" as an attending physician at one of these pre-World War II installations, I had foisted on me the formidable and usually boring chore of sifting the reams of records amassed over the years by some of these pensioners. It was my function to review the old files, digest the Himalaya of data and then come up with a *readable* two-page summary.

It is sobering to trace the perpetuation (on the chart) of an obviously no longer tenable diagnosis. A very fine diagnostician can err in calling

a patient's condition "malignant, eosinophilic granuloma" (the lethal, Wegener variant of periarteritis nodosa). But — if the patient is alive and well 20 years later — what moment of inertia prohibits the *changing* of that deadly diagnosis?

A Garish Grisette

Let us desist from declaiming and revert to Lee Lahl, the lady of our careful concern here. While making the day's rounds, I had my first glimpse of her vivid-red, garish hairdo. Seated in her wheelchair, she was having an animated conversation with a volunteer worker. Very neatly clothed in her concept of the latest "in" attire, her still youthful face was obnubilated by layers of carefully applied make-up. The "tweedies" on the palpebral margins and the gobs of purple mascara did not obscure entirely the flashing eyes. Large white teeth (her own) were glimpsed with the ambit of the heavy red paint circling her lips.

The nurse gave me the woman's chart so that I could glance at the "off service" notes of my immediate predecessor. It was surprising to read that the 47-year-old lady had had, "Still's disease since age 9 . . . and had since been on intermittent treatments of various sorts for her 'stiff, painful joints and difficulties in walking.'" In 1960, she had had

bilateral Smith-Peterson cup arthroplasties performed at a very famous orthopedic hospital. After a year at still another hospital, she had reached her present domicile. There is, "marked adductor spasm and coxa vara when the patient sits or lies." However, "can stand and walk independently . . . Only present medications are for hip pains and insomnia."

As I toured through the ward corridor, I came up to the patient's wheelchair. The nurse introduced me. I was greeted in a very pleasant voice; a hand was extended for a very firm handshake. There was not a trace of any visible or palpable arthritic crippling of either upper extremity! Did this lady indeed have rheumatoid arthritis? And, since early childhood?

Throughout my professional career, arthritic diseases have been of special interest to me. Rheumatic fever has stalked the women of my family. My mother was laid up with it for two long, invalid years; my wife's sisters had it. It struck BOTH my daughters, while sparing me and my son. On my father's side, two of my first cousins were afflicted with spondylitis deformans, the Bechterew, Marie-Strumpell disease. The older one, a World War I British veteran, lived to develop the extreme

deformities that made him totally helpless; his devoted wife nursed him until pneumonia gave him merciful release not too long ago.

As a general practitioner and then an internist, I have worked in arthritis clinics for many, many years; I have made a point of studying my patients and the literature to the limit of my capacities. In Case #9 (See my volume, *Case Capsules*), "The Arthritic Arpeggio", rheumatoid arthritis was discussed in some detail. Lee Lahl was my very first encounter with a long catalogued instance of Still's disease, juvenile rheumatoid arthritis, that had failed to go on and develop the horrifying deformities that cripple the upper extremities and form so distinctive a hallmark that a diagnosis can be made at the first, casual glance!

Back at the nurses' station, I went to her chart again. Carefully, page by page, I leafed my way through the folder. There was the report of the hip x-rays taken when she was first admitted to our facility. The Smith-Peterson cup arthroplasties were factually reported. I went to view the films (Figure 1). Who could gainsay their presence? And had the disease involved *only* the hip joints — and stopped progressing? But that would be the very first instance on record of such an event!! Incredible, if true! But who was I to contradict the long series of experts who had seen and treated this

woman over the lengthening decades?

Baffled, I searched through the ancillary laboratory data: *everything* normal! I ordered a total body skeletal survey. Excepting for "osteoporosis . . . and . . . some shoulder changes possibly consistent with rheumatoid arthritis . . . only mild osteoarthritis." The sedimentation rate was 22; latex fixation — negative; electrophoretic pattern of serum — normal; normal Hb, w.b.c. and differential; uric acid, 5.7; blood sugar and BUN, normal! Normal . . . normal . . . normal!

Diurnal Demons

Before even considering the publication of a genuine FIRST, I re-read Lee Lahl's transfer summary. It was from a world famous institution at which she had spent a year after her orthopedic surgery. Her background was ably recapitulated "Born in Sicily . . . arrived in United States with family before age of 10 . . . horrible social background . . . father involved with Mafia, drunkard, wife beater . . . family well known to Welfare. At age 9, Lee attended the OPD at M— Hospital . . . treated for severe, crippling hip and leg pains which prevented attendance at school . . . never got beyond third grade.

"Married at age 17 to a narcotic addict she had met at a dance hall [sic!]. First daughter a year later . . . separated repeatedly . . . bore another daughter with same father when she was 35. In 1951 started on gold therapy and intensive physiotherapy at C— (a most prestigious institution). Very considerable improvement . . . Severe regression of symptoms after final break-up of her home life in 1956. Admitted to hospital for surgery for fibroids the same year. In and out of hospitals continually . . . hip surgery in 1960-61. Still another hospital for another year . . . Accepted for infirmary care at our facility where she has remained since."

Her annual physical examinations have been consistently within the

limits of normal: the cup arthroplasties excepted, of course. Our Social Service made the interesting observation anent the patient's extreme piety. She went on a pilgrimage to St. Anne of Beaupre up in Canada annually. Always attended all religious services . . . very active with other Catholic activities . . . has talked about becoming a nun.

The physiotherapy and occupational therapy heads informed me that she was very active in their departments. "She won't spread her legs but she can walk with a walkerette and could — but won't — use tripod canes. She is an eager participant in chorus, weaving, patient council . . . tries to help other patients with Aid to Daily Living."

Various preceding attendings had requested psychiatric consultations. Was the failure to attain independent ambulation due, possibly, to hysteria or malingering? The surgery seemed to have been eminently successful and yet she continued wheelchair bound. The psychiatrists came up with tidbits like, "hostile . . . very dependent and yet very demanding . . . no delusions or hallucinations . . . severe identity problem . . . great fear of her inadequacy. Background inhibitions **NEED EXPLORING** in *dep:h!*" Diagnosis: severe psychoneurosis.

Not too long ago, on a convenient free morning, I took the time for a most meticulous physical examination of Lee Lahl. Pathological findings were few and far between. The head and neck were absolutely normal. The eyegrounds were quite all right; there was some hearing loss (documented from away back). The neck was completely supple, had no palpable masses and the carotid pulses were serenely strong and regular. The chest was completely symmetrical; the lungs were clear to percussion and auscultation. The blood pressure was just right and the heart had RSR with exactly correct rate; there were nary a murmur to be heard. The abdomen bore the scar of the 1958 hysterectomy but, otherwise,

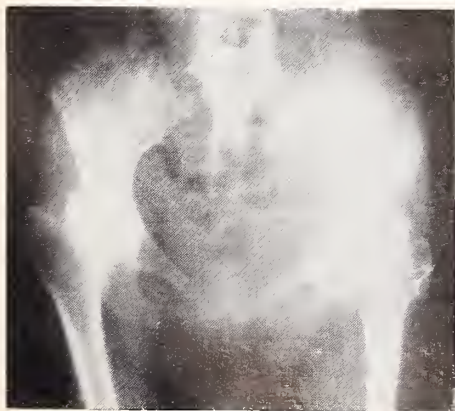


FIGURE 1
X-RAYS show the Smith-Peterson cup arthroplasties.

was devoid of pathology. The upper extremities were gone over in minute detail. All joints had their full range of motion; but no abnormalities were visible or palpable. The lower extremities presented the *raison d'être* for her being wheelchair bound. The knees and the ankles were absolutely normal in all respects. The hips could be flexed partially; they were held in rigid hyper-adduction. Even my most discreet, gentlest effort at *AB*duction elicited screaming protests! I got nowhere beyond creating extreme agitation! It was just impossible to even attempt a rectovaginal scrutiny!

Nonexistent Neuralgia?

All this time, the wise old nursing supervisor had been standing by the head of the examining table. Soothingly, she tapped Lee Lahl's cheek, "Come now, Lassie! No one's agoing to *tumble* ye here! Relax!" Her softly uttered, rich, Irish brogue struck just the right note — and my thoughts switched right into her groove! The older I get, the more respect I attain for the ideas of the paramedical personnel!

We terminated the examination. As we walked away, I said to her, "The psychiatrists should have heard you just now! Is *that* her problem?"

"Well, doctor! I don't have to tell you that Lee has this problem when she is lying down. She can stand — and did you ever watch her when she is singing with the chorus? Her legs do spread and she stands firmly without supports! And I know that she goes to the bathroom by herself: *AFTER* she closes the door."

Over the succeeding months, Lee Lahl and I had many random chats. I began to acquire the woman's confidence; by dribs and drabs, her confidences began to make sense. But — how come that surgery? With kindled curiosity, I took the time to go over to the Orthopedic Hospital. The record librarian made available to me all *FOUR* thick folios comprising Lee's complete record.

The summary, of course, was already well known to me. But there were most interesting additional items scattered here and there. As far back as 1951, the x-ray report to the arthritis clinic anent the just admitted patient stated, "Knees and hips do *NOT* have the roentgen appearance of rheumatoid arthritis." Nevertheless, in the arthritis clinic, the resident started her on gold "as a *trial* in addition to the physiotherapy *AND* the psychotherapy!!" In June of 1953, "joints better on P.T. She has many home problems." Again, the reference to *PSYCHOTHERAPY* — a recurring refrain! Same month, the x-rays, "mild changes of osteoarthritis . . . minor osteophyte formation. . . . There is *NO* evidence of rheumatoid arthritis. Has Sudeck's atrophy been considered?" A devilishly good question that no one seemed to have pursued further.

Then, over the next several years, more and more notes by this attending and that resident, "Patient *DEMANDS* surgery for the correction of her intolerable hip pains. She is convinced that she will be able to be normal again. In spite of all normal objective findings, it just *MIGHT* be possible that the adductor tendons could be severed and articular adhesions freed by the insertion of cup arthroplasties!!!" The patient's clamor rose to a crescendo; succeeding doctors became more and more amenable to persuasion.

Incredible? Well, the surgery was scheduled and was performed: first, the one side and then the other. The detailed recitatif need not detain us. Still the surgical reports were not describing rheumatoid arthritic tissues; and, where did the tissue reports vanish? Into limbo? And for *both* hip operations? In any less formidably famous institution, it would have been a horrendous hiatus; a reason for a full scale investigation. Things being as they are, I mention the bare fact most hesitantly. The adductor tenotomies and the insertion of the

cup arthroplasties are recorded routinely. Still, it is curious that the *FIRST* final diagnosis was, "*CONVERSION REACTION* superimposed on her organic pathology." The "rheumatoid arthritis" was an almost obvious afterthought . . .

Tumultuous Tortuosities

All this data (and much more) fitted into what I had learned from my seemingly idle chats with the patient. The oldest of a numerous brood, her very earliest memories are nightmares of a tipsy father coming home late at night to their wretched, one room hovel back in Sicily. The drunken lout would tumble Lee's mother even as the children would cower in the most distant corner of their wretched abode. These iterative pudendal probes as seen by the light of a guttering candle, seared her childhood indelibly. As we have said already, the child can be "battered" mentally even more cruelly than mere physical trauma.

And then — when she practically fled from her parents after they had settled in New York — she stumbled into a hasty marriage with an almost casual acquaintance who had picked her up at a dance hall: of all places! On their wedding night: her husband performed the identical act she had witnessed so many times — but, this time, on her! The brutal violation



tore her physically and forever crushed her psyche. No wonder that Lee Lahl's concept of marriage is, "a woman is a wife SOLELY to gratify her husband sexually!!"

The exploration of Lee Lahl's tangled situation still leaves some untidy obscurations. I remain amazed at her being able to "sell" the hip surgery (and not once but twice) to such orthopedic luminaries. I do

know that she is left with the physical complications of an *iatrogenic idiopathy*. But she also has embedded in her mind all the idiosyncrasies of behavior arising from male created havoc. At present, she has adjusted to her limited environment. The ward is very much her home. Both her daughters have been taken care of by others. Her narcotic addict husband has vanished from her ken.

Are we justified in turning her over to the psychiatrists — who have been right in their instincts all along? Would shock therapy be justified here? Could a tolerable situation be muddled by further meddling now that a clear view of the entire history has been obtained? What do you think? ◀

1270 Fifth Ave.

New York, N.Y. 10029

WANTED

PLATTSBURG, CLINTON COUNTY, MISSOURI

Warrant has been issued for the arrest of Mrs. Betty Barton, Graduate Nurse, (St. Louis Baptist Hospital, defunct 25 years), registered in Missouri. Age 53, appearance that of the 40's. Height, 5 ft. 5 inches. Weight, about 120 lbs. Auburn complexion, but dyes hair; recently wore large mop of grey hair, previously reddish-brown; soft spoken, at times uses child tones.

Mrs. Barton left the community with a mortgaged auto, lavender color Monza Corvair with white interior; license number JF0239, speedometer 15,000 to 20,000 miles. She owed large sums of money to business firms and individuals.

She will probably seek employment in a doctor's office, home for the aged or one for children, or an industrial plant. She is intelligent and very capable in her work.

Recently a warrant was issued for her arrest for jumping a motel bill at Columbia, Boone County, Missouri.

Any information on this person should be sent to:

RAY R. BOYD,
Sheriff, Clinton County, Missouri

The Cancer You View

CHARLES R. THOMAS, M.D.
Indianapolis*

Edited by

Edwin E. Pontius, M.D.

Indianapolis*

A 32-year-old housewife, para 3, gravida 3, was seen for a routine examination. She had no complaints and denied abnormal bleeding, pain, and discharge. The cervix appeared as pictured.

What is your diagnosis?

What steps would you employ to verify this diagnosis?

How would you treat this lesion if it is cervicitis?

How would you manage this problem if it is cancer?

For diagnosis and discussion, please see page 1099.

* From the Pathology Section, Methodist Hospital of Indiana, Inc., Indianapolis 46207.

Supported by the academic activities and financial assistance of the Methodist Hospital Graduate Medical Center and the American Cancer Society, Indiana Division, Inc.



HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

- * 125 In-patient beds —
- * Day Hospital program —
- * Full time attending staff of psychiatrists —
- * Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
- * Qualified staff of psychologists —
- * Social Service department —
- * Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

James L. Hagle
Administrator

Electrocardiogram of the month



Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Pulmonary Emphysema vs. Myocardial Infarction

CHARLES FISCH, M.D.
Indianapolis

*I*N two preceding "ECG of the Month" articles dealing with the problem of the ECG pattern in chronic obstructive pulmonary emphysema (COPE), it was stressed that not infrequently the ECG of COPE simulates that seen in myocardial infarction and that the differentiation between the two must be based on the overall clinical picture. The purpose of this communication is to present such an example and to point out that it is absolutely impossible to differentiate between COPE and myocardial infarction without taking into account the overall clinical picture.

The features pointing to COPE in Figure 1 are the prominent P waves in II, III and AVF with a frontal axis of about $+60^\circ$ and perhaps the marked ($+180^\circ$) right axis deviation of the QRS. On the other hand, lack of a significant R wave in V-1—V-6, especially with the loss of R in V-5 and V-6, may be due to extreme clockwise rotation seen in COPE or extensive anterior myocardial infarction with an actual loss of myocardium. The vectorcardiogram confirms the rightward orientation of electrical forces in the frontal plane with posterior shift of the loop in the horizontal plane but does not help to differentiate between the conditions in question. The problem has to be resolved on clinical grounds. ◀

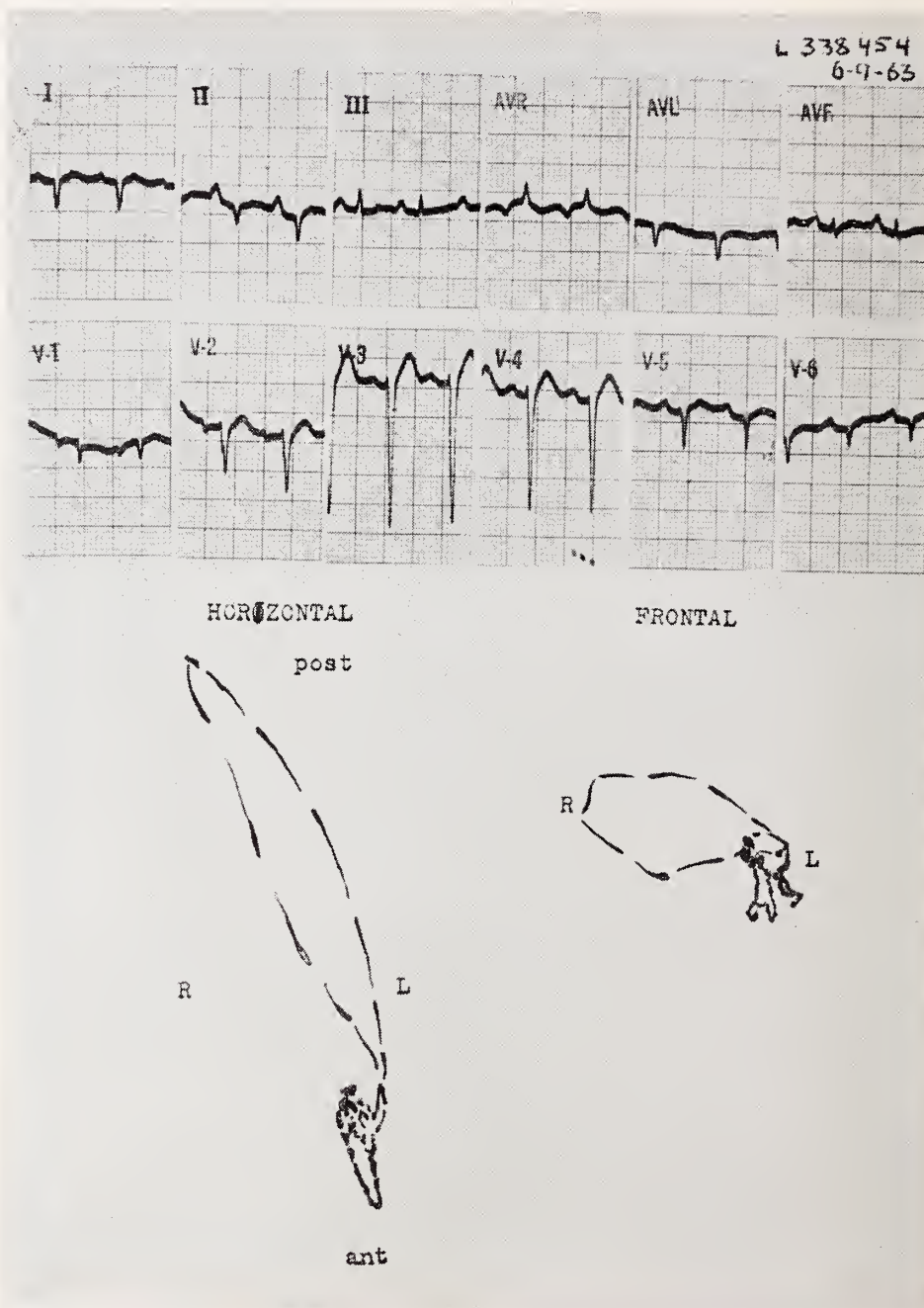


FIGURE 1
FEATURES pointing to COPE are the prominent P waves in II, III and AVF (see text for details).

Coming home is wonderful

when you have Blue Cross-Blue Shield

After a long hospital stay, coming home is wonderful—if you have let Blue Cross-Blue Shield do the worrying for you about health care bills.

Blue Cross—Blue Shield provides generous benefits at the hospital, makes realistic allowances to your doctor.

And in these days of excellent, but expensive, health care, that's more important than ever.

Employers prefer Blue Cross-Blue Shield, too. They have no admission or claims forms to worry about—they're not running a branch office for some health insurer. All paperwork is handled directly between Blue Cross-Blue Shield and hospital and doctor.

Yes, coming home is wonderful when you have Blue Cross-Blue Shield.

For you, because it was a worry-free homecoming—for your employer because your claim was processed so efficiently he probably didn't even know about it.

That's why people say—from the heart—"I don't know what we would have done without Blue Cross-Blue Shield."



Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series of ads being run in key Hoosier newspapers)



"You're up ten pounds since your last physical. We're going to have to do something about that."

Get them while they're easily reversible.

Obesity doesn't happen suddenly. This insidious process has its beginning—and the chances of reversing it are better—during the *first 10 to 15 pounds of weight gain*.

When a new dietary pattern must be established, consider the adjunctive use of **BAMADEX SEQUELS**. Combining the proven *anorexiogenic* action of d-amphetamine with the *tranquilizing* effect of meprobamate, **BAMADEX SEQUELS** controls appetite throughout the day, usually with a single capsule daily.

Contraindications: Dextro-amphetamine sulfate: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions to meprobamate.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Excessive use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised, especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on the drug. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of preexisting symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dosage and avoid operation of motor vehicles, machinery or other activity requiring alertness. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients

with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness. Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia; the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Bamadex[®] Sequels[®]

Dextro-amphetamine sulfate (15 mg.)
with Meprobamate (300 mg.)

Sustained Release Capsules



LEDERLE LABORATORIES

A Division of American Cyanamid Company
Pearl River, New York

466-7

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

Fracture of the Distal Radius with Ulnar Nerve Injury

WILLIAM A. STARK, M.D.
Michigan City

ULNAR nerve lesions associated with fractures of the distal end of the radius have been reported by Zoega, who described three cases in 1966.¹ In one of these injuries, full function of the paralyzed ulnar intrinsic muscles returned in five months, with no specific treatment other than reduction of the fracture. In the other two cases, the ulnar nerve was explored and found to be contused. In none of the three cases was the nerve severed.

A case is now presented in which actual severance of the ulnar nerve occurred with an open fracture of the distal end of the radius. This is an unusual combination of injuries and occurred with severe trauma.

Case Report

A 56-year-old white male was admitted to the hospital on December 7, 1963, as a result of a fall from a ladder. The patient stated that he fell approximately six feet, landing on his outstretched left hand. He had immediate pain and deformity. There was a laceration on the volar aspect of the left wrist and the typical "silver fork" deformity.

There was anesthesia of the left little finger and the ulnar aspect of the left ring finger, as well as the corresponding portion of the hand. The ulnar innervated intrinsic muscles of the hand all showed no activity. Routine laboratory studies

on admission were all within normal limits. X-rays revealed a comminuted fracture of the distal radius with dorsal displacement (Figure 1).

The compounding wound was explored under general anesthesia. There was partial severance of the flexor digitorum profundus tendon to the left little finger. The flexor carpi ulnaris muscle and the ulnar nerve were also completely severed.

The wound was debrided and a primary repair of the involved structures performed. The ulnar nerve was repaired with multiple fine silk sutures through the epineurium. The skin was then closed and a closed reduction of the fracture performed. A Steinmann pin was placed through the second and third metacarpals and incorporated into a long arm cast. X-ray examination after the closed reduction showed satisfactory, but not anatomic, reduction of the fracture.

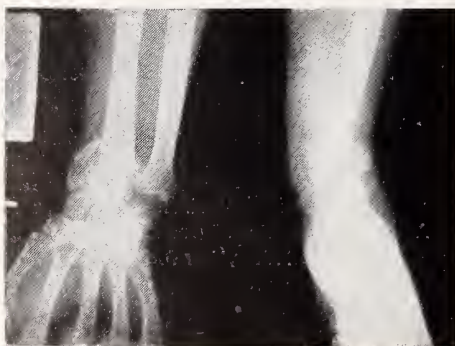


FIGURE 1
ROENTGENOGRAM taken December 7, 1963, showing the unreduced fracture.

The wounds healed without complication. The long arm cast remained on until December 30, 1963, at which time the Steinmann pin was removed and a new short arm cast applied. The short arm cast was removed on January 11, 1964. At that time there was good position of the fracture fragments.

The patient was then started on exercises to increase the range of motion of the wrist. Through the following weeks a Tinel sign was noted to be progressing gradually down into the palm of the hand and into the fingers. The patient's sensation gradually improved, until at the last examination in June, 1965, he had protective sensation over the fingers. The ulnar intrinsic muscles recovered sufficiently to allow all movements, but there has been persistent weakness.

Summary

A case of fracture of the distal end of the radius associated with complete severance of the ulnar nerve is presented.

BIBLIOGRAPHY

1. Zoega, H.: Fracture of the Lower End of the Radius with Ulnar Nerve Palsy, *J. Bone and Joint Surg.* 48B: 514-516, August, 1966.
1412 Franklin St.
Michigan City, Ind. 46360

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Massive Pulmonary Infarction

ERICH K. LANG, M.D.
Indianapolis*

A 41-year-old white male was admitted with classical symptoms of acute appendicitis. Typical rebound tenderness, guarding of the right lower abdomen, elevation of the white count and a classical history of diarrhea and abdominal pain affirmed the diagnosis. Within four hours after admission, the patient was explored and a gangrenous appendix removed. During the ensuing four-day-period, he improved readily and was scheduled for discharge on

the morning of the fifth day.

However, during the fourth night of his hospital stay, the patient experienced sharp pain in his right chest. The house physician found the patient dyspneic, the pulse rapid and irregular and the blood pressure 72/40. In view of these findings and the classical history, the diagnosis of a massive pulmonary infarct was advanced.

A pulmonary arteriogram, performed within two hours after onset

of symptoms, demonstrated almost complete occlusion of the main right pulmonary artery (Figure 1). Huge mutilobular filling defects were demonstrated in the upper branches and in most of the lower branches of the right pulmonary artery. There were also filiform filling defects in the left upper pulmonary arteries. The arteriographic findings confirmed the diagnosis of massive pulmonary infarction.

A surgical embolectomy was carried out within five hours, and the emboli were removed from the right and the left pulmonary arteries.

Comment

Pulmonary embolization is a common complication of many medical and surgical conditions. Frequently, pulmonary infarction is misdiagnosed as bronchopneumonia. The diagnosis of pulmonary infarction can be suggested on the basis of a classical clinical picture. Plain roentgenograms confirm this diagnosis by demonstration of a segment of relative avascularity in the early phase, or on the basis of triangular or wedge-shaped segments of atelectases, apparent eight to 12 hours after onset of symptoms.

If the condition of the patient warrants surgical intervention, prompt confirmation of the diagnosis by pulmonary arteriography is the method of choice. A catheter introduced into the antecubital vein is advanced

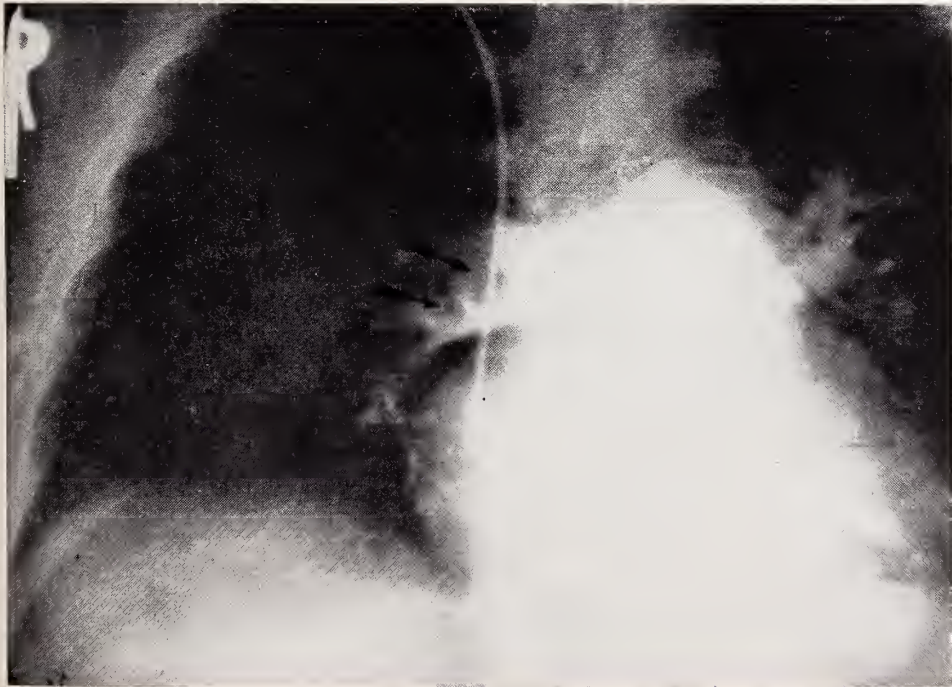


FIGURE 1

A one-second phase roentgenogram demonstrates lobulated filling defects in the right main pulmonary artery. Only a few branches of the right lower pulmonary artery show dye filling. Otherwise, the right pulmonary arterial bed appears to be completely devoid of circulation. A filiform defect is demonstrated in one of the branches of the left pulmonary artery, ascertaining that there is also embolization on the left side.

under fluoroscopic control into the main pulmonary artery. Forty ccs. of contrast material are used for opacification of the right and left main pulmonary arteries. Serial films will demonstrate the main pulmonary

arteries, and allow comparison of flow into the right and left segmental pulmonary arteries. A definitive diagnosis can be readily established, and the feasibility of surgical correction effectively assessed on basis

of this study. Lung scans are primarily advocated for confirmation of pulmonary shower emboli or small pulmonary infarcts, which are not felt to necessitate surgical embolectomy. ▲

Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1967 annual meeting of the Indiana State Medical Association, Oct. 9-12 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Ray H. Burnikel
517 Sycamore St.
Evansville

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name _____

Address _____

City _____

Type and number of pieces to be displayed: Photography _____

Sculpture _____

Crafts _____

Painting _____

Other _____

Estimated amount of space required—lineal or square feet _____

Other information _____

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.^{1,2} For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."³

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."⁵

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."⁴

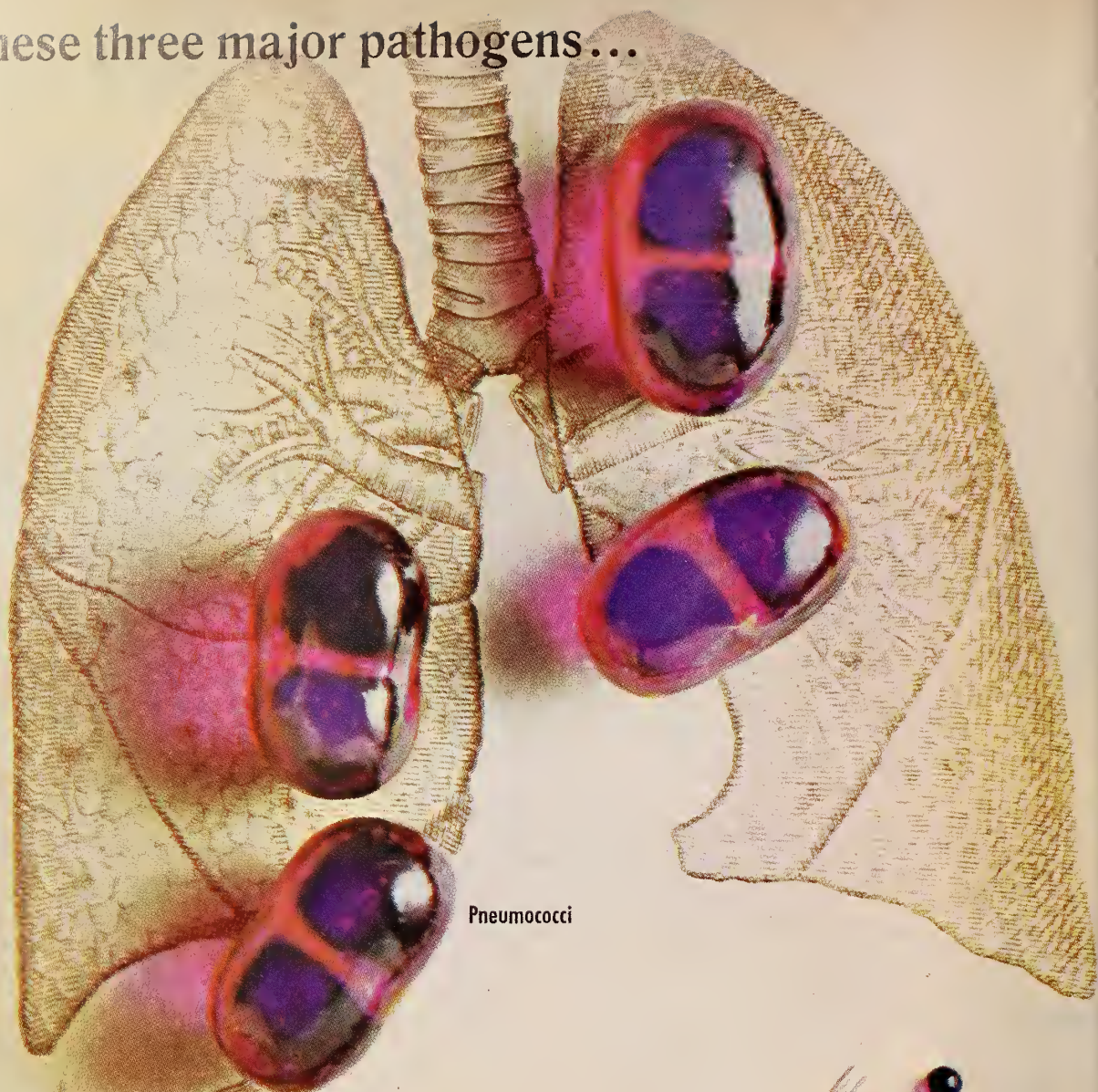
4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated⁶ skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement..."⁷ And there is little likelihood of sedation.⁶

Indicated for relief of skeletal muscle spasm. Contraindicated in hypersensitive patients. Side Effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. Also available: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottscholk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Holl, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

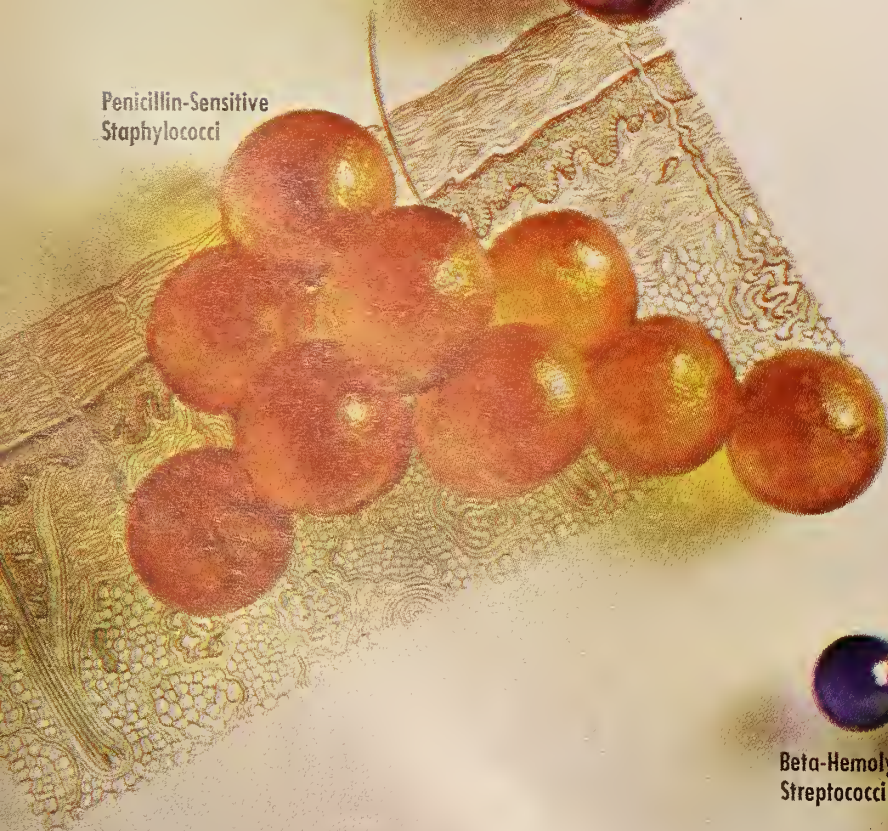
A-H-ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220

Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



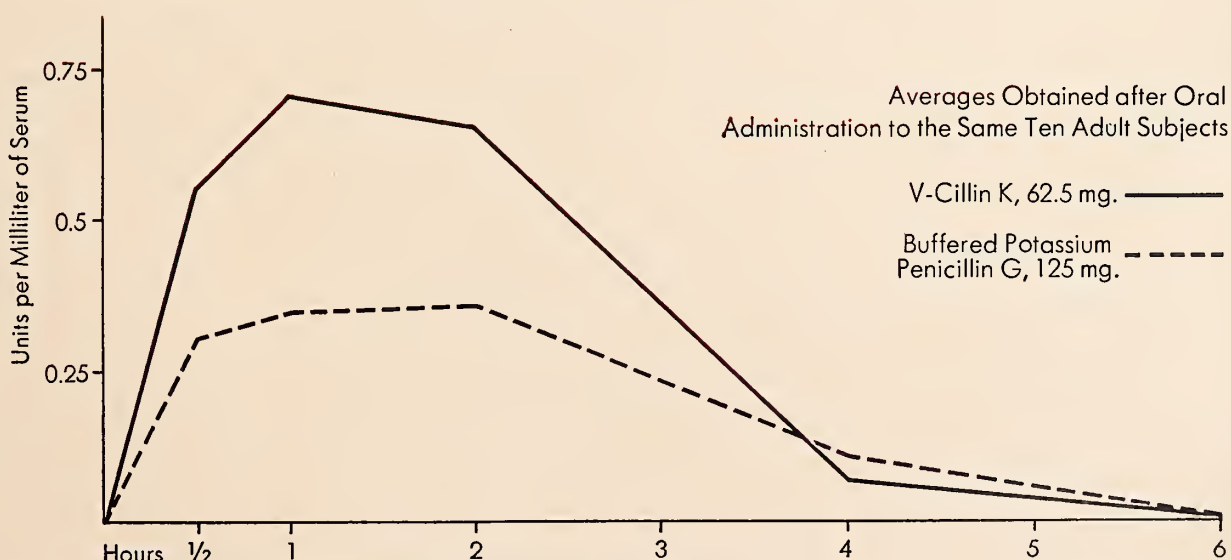
V-Cillin K[®] provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive)		Streptococcus, Group A		Diplococcus Pneumoniae	
	MIC (mcg./ml.)		MIC (mcg./ml.)		MIC (mcg./ml.)	
	Median	Range	Median	Range	Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food

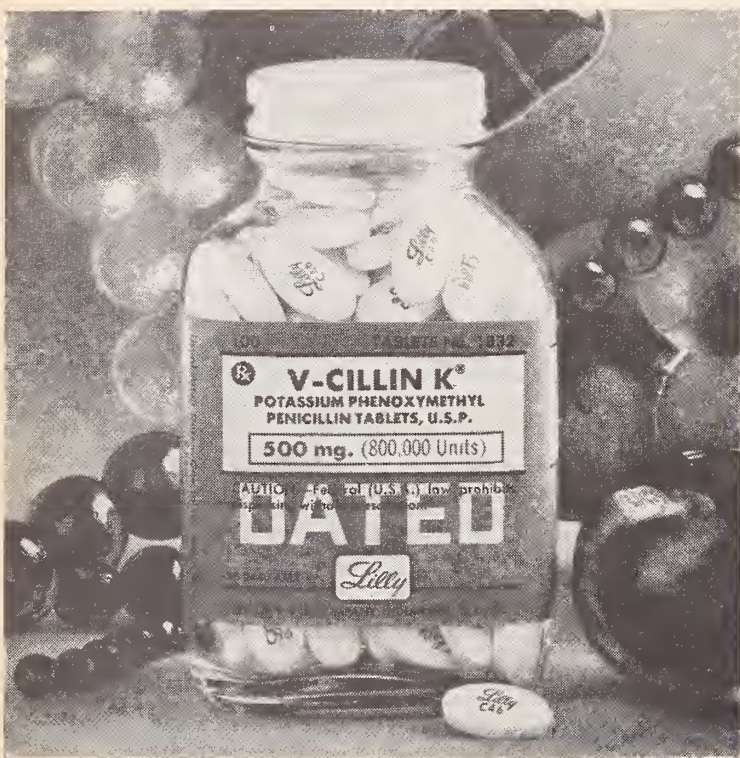


Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K[®]  700867
Potassium Phenoxyethyl Penicillin

(See next page for prescribing information)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxy-methyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxy-methyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K, Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

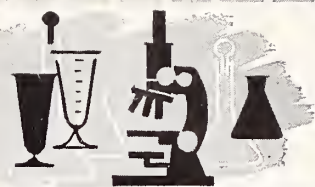
V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Path-finder

PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

The Routine Throat Culture

THE bacteriological evaluation of the flora of the throat and adjacent areas can be of significant importance in establishing the etiological diagnosis of upper respiratory infections. Because of the higher incidence of serious disease and the two major sequelae of group A streptococcal infections (nephritis and rheumatic disease), throat cultures are of marked significance in children. In the mature or aged patient, the importance of this procedure is lessened. Possibly, the major contribution here lies in indicating the therapeutic course to be followed in more chronic infections.

Normal flora: A minor problem in evaluation of the results of throat cultures is the finding of various types of bacteria from the throat that constitute the normal flora. Alpha hemolytic streptococci and non-pathogenic *Neisseria* species, diphtheroids, and micrococci are normal residents of the throat and are known to increase in times of upper respiratory infection without being directly associated with the infection. Lactobacilli, coliform bacilli, and yeasts are also encountered. For this reason, the isolation of these organisms from throat culture in normal or moderately increased numbers is of limited significance.

The more frequently encountered pathogenic organisms are the Group A hemolytic streptococci, the pneumococcus, members of the *Haemophilus* group (notably, *H. influenzae*), *Candida albicans*, and the organisms associated with Vincent's angina. Infrequently, Group A streptococci will be isolated from the normal throat of a carrier. *Neisseria meningitidis* also may be found in the normal throat, although the carrier rate for this organism is very low.

Group A hemolytic streptococci: *Streptococcus pyogenes* is an overt pathogen causing such diseases as septic sore throat, pharyngitis, laryngitis, tonsillitis, and scarlet fever. It is well known that the recognition and treatment of infections caused by these organisms is essential to the prevention of their more serious sequelae. Unfortunately, streptococcal throat infections cannot be diagnosed on clinical signs with any great degree of accuracy. While possibly 90% of streptococcal infections are caused by the Group A streptococci, many infections of the upper respiratory system caused by other organisms are clinically similar.

Diplococcus pneumoniae is frequently found in the throat, and carrier rates in normal adults for *D. pneumoniae* may range as high as 50%. In children, the organism, in the presence of inflammatory conditions, should be considered patho-

genic. In addition to causing pneumococcal pneumonia, this organism frequently causes infections of the sinus, middle ear, pharynx, and meninges.

Haemophilus influenzae is considered pathogenic for young children. Pharyngitis or middle ear involvement may progress to a severe and frequently fatal obstructive respiratory syndrome or to meningitis. In the adult, the organism is much less invasive although chronic sinus, middle ear, and mastoid infections are not uncommon. A closely related bacillus, *Bordetella pertussis*, is the causative agent of whooping cough and may be isolated from either throat culture or cough plate.

Staphylococcus aureus less frequently infects the tonsils and sinuses of both children and adults, and is associated with a purulent discharge. Coagulase-positive *Staphylococcus aureus* is often found in the nasal passages in the absence of infection. In adults, carrier rates of 20% to 40% are not uncommon.

Diphtheroids: While not pathogenic, diphtheroid bacilli from the throat are significant in that, when found, they must always be differentiated from the diphtheria bacillus, *Corynebacterium diphtheriae*. Diphtheria in this country is a rare disease, although the visualization of large numbers of diphtheroids on a smear from the throat necessitates

* Prepared by the Section on Practice of Pathology in the Private Office, College of American Pathologists.

ruling out the toxigenic diphtheria bacillus.

Candida albicans: This organism is frequently found in the normal mouth and throat where it constitutes part of the normal flora of many persons. It becomes significant only when found in extremely large numbers in the presence of some oro-pharyngeal pathology. When this state exists, the organisms are present in extremely large numbers and can be seen on the surface of the membranes of the mouth, tonsils, pharynx, etc. as whitish mats which can be scraped off with difficulty.

Neisseria species: *Neisseria meningitidis*, the meningococcus, is a serious pathogen. Although it may be present in a carrier state, finding this organism in throat culture should always be considered significant enough to warrant its eradication. Septicemia and meningitis can occur in adults as well as children following infection of the nasopharynx.

While the two more commonly known *Neisseria species*, *N. catarrhalis* and *N. sicca*, have been known to cause upper respiratory involve-

ment, infections of this type are extremely rare. The organisms are recognized as constituents of the normal flora. Occasionally, they have been implicated as sensitizing agents in allergic conditions (allergic rhinitis).

The organisms of Vincent's angina: The causal organisms of this disease are not routinely cultured from the throat. The disease is caused by a group of organisms and is readily diagnosed by examining smears microscopically from infected areas. When infection exists, great numbers of these organisms are found in the presence of pus cells. If clinical signs of the disease are also present, the diagnosis is confirmed.

Direct smear results frequently may be more contributory than results from cultures. This is particularly true when the more fastidious organisms are seen on the direct smear but show delayed growth or fail to grow on culture. Also, the smear will reveal the presence, or absence of pus cells that strongly indicate bacterial, rather than viral involvement. Another benefit of the direct smear is that it indicates the significance of

the organisms isolated from culture, their relative numbers, and whether an adequate specimen was obtained. Frequently, more extensive and refined staining procedures using fluorescein-tagged antibody and the ultraviolet microscope may reveal the presence of group A streptococci on the same day the specimen was taken rather than delaying the findings until the organisms are identified from culture.

Many other pathogenic organisms may be isolated from a throat culture. Those presented above are more frequently encountered. Although adults are more resistant, or tolerant, to diseases caused by some of these organisms, children appear to be much more susceptible. Culture and direct smear results should always be interpreted in this light.

The specimen: To afford the physician the greatest amount of information, adequate material must be taken by sterile swab from involved areas of the upper respiratory passages. Since material is needed for stain and culture, a minimum of two swabs is essential. ◀

I.U. School of Medicine Postgraduate Courses (Division of Postgraduate Medical Education)

September 6 — Recent Advances in Diabetes Therapy, to be held at Marion County General Hospital.

September 13 — Emotional Problems in Surgery and Obstetrics, to be held at the W. S. Major Hospital, Shelbyville.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46208.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth
Street, Terre Haute; Lall G. Montgomery, M.D.,
Ball Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:	Term Expires
Harold D. Lynch, M.D., Evansville	Dec. 31, 1967
Jene R. Bennett, M.D., South Bend	Dec. 31, 1967
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

**The Doctor is Losing
His Voice***

Paul Harvey
ABC News Commentator
Chicago, Ill.

IN handling medical matters, the press characteristically tends to underscore the sensational.

Sometimes we can't help it.
A false alarm may be unavoidable in the instance of a novice researcher prematurely excited about some imagined breakthrough. Also, we shall always have with us some physicians who are less reluctant than others to focus attention on themselves with dramatic utterances.

But the greater risk to the public and to the profession derives from a misleading public statement on matters of medical ethics, philosophy and principle.

A news analyst cannot possibly be an authority on every subject which he is required to discuss. Generally, therefore, we come to rely on the counsel of experts in each field.

In a matter involving some facet of space flight, there are acknowl-

edged spokesmen for both government and industry.

In most other physical sciences it is comparatively easy to seek, find and consult with an official or quasi-official spokesman.

Big Steel has a spokesman; so do the steelworkers.

In sports we take our questions to the persons with the best batting average. We ask questions on military weapons and tactics of military specialists whom history has proved right more often than wrong.

But in the urgent policy matters relating to medicine where can we go?

Since Fishbein, the news media have most often accepted as "the last word" the word of the Surgeon General of the United States.

I do not believe the surgeon general, however capable he may be, is the proper person to speak for the medical profession. He is a bureaucrat, necessarily parroting the party line of any incumbent political administration.

Recently, in such sensitive areas as federal money for private medicine, expanded social security, trade-name versus generic drugs, participation versus non-participation in Medicare, direct billing versus assignment, certification of medical necessity for Medicare and Medi-

caid, drug costs and hospital rates, areawide planning for hospitals, utilization review committees, the news media have been brainwashed with the "Government" point of view—because modern medicine has no other effective voice.

I say what I am saying with much respect for Dr. Blasingame, whom I have sought out for guidance or a statement on some of these issues. But his prerogatives in enunciating socio-economic policy are presently hopelessly restricted.

Since the old jam-packed press conferences where the *AMA Journal* editor would announce the AMA diagnosis, prognosis and prescription in matters of national interest and public policy—the image of the medical profession has become blurred or blackened.

In respectfully recommending that the AMA again figure out some way effectively to speak through someone with one voice, I am aware of the risk involved. The spokesman might turn out to be a believer in the Big Government philosophy.

But I am willing to take that risk, because he can't be any further left than a politically-appointed surgeon general.

Every night at six, an audience of forty million viewers is available to some articulate, uninhibited, pref-

* Abstract of the principal address delivered by Paul Harvey, before The Conference of Presidents and Other Officers of State Medical Associations, Atlantic City, New Jersey, June 17, 1967. The complete text is published in this issue of *The Journal* beginning on page 1078.

erably wavy-haired medical statesman-spokesman. And every night you don't supply one, the government does.

The Social Security Disability Program in Indiana

THE Indiana agency charged with determining disability in workers for purpose of disability benefits from the Social Security Administration is distributing a booklet under the above title to all physicians in the state.

The important facts about the Social Security disability program are explained clearly and concisely. The physician's part in the determination of disability and the method of establishing benefits are outlined. In addition to the cash benefits, the operation of the program in Indiana to accomplish as much as possible in rehabilitation and possible return to gainful employment is emphasized.

The booklet will be received this month and should be read by all. It is well written and short enough to warrant perusal by even those who may have but one patient eligible for consideration by Social Security.

All programs of this nature depend on written reports for the bulk of data necessary for proper determinations. Dr. E. B. Haggard, author of the booklet and chief medical consultant for the Indiana agency, stresses that not only the initial reports of findings are necessary, but that subsequent reports of response to treatment, reports of functional ability at various intervals and statements of prognosis in relation to possible return to work are especially useful to his staff.

The booklet is valuable. It should be read carefully and kept on file for future reference.

PMA President Replies to Critics

REMARKS made in the U.S. Senate concerning drug prices and the

plans of Senator Gaylord Nelson to open hearings on the drug industry caused C. Joseph Stetler, president of the Pharmaceutical Manufacturers Association, to point with pride to the record of the American pharmaceutical manufacturers in research and in the introduction of many drugs which have lessened the economic cost of illness, shortened the time away from work because of illness and prevented many diseases almost entirely.

Mr. Stetler expressed amazement that there should be so much discussion about the high prices of modern drugs when as a matter of fact:

1. The latest federal government index of manufacturers' prescription drug prices is 92.6. The decline has been steady from the 1961 base period of 100.

2. The government index for retail prescription drug prices has followed a similar decline. The newest report places it at 90.6, also an all-time low.

3. Drug prices have clearly defied the inflationary trend of the 1960's. The latest overall Consumer Price Index stands at 115.0.

4. Prescription drug costs now represent a smaller share of medical care spending by Americans than ever before in history. Prescription drugs account for less than ten cents of each medical care dollar.

5. The pharmaceutical industry has been praised both in 1966 and 1967 by President Johnson's Council of Economic Advisers as a force against inflation because of its declining price levels throughout the present decade.

Advertising Income of Nonprofit Organizations

THE Internal Revenue Service has proposed a regulation which would subject the profits from advertising in publications of certain tax-exempt organizations to a 48% tax on the supposition that such advertising is an "unrelated business."

The tax-exempt organizations of the category referred to include medical societies, medical associations and similar professional organizations of the legal and dental fraternity, as well as Boy Scouts, Girl Scouts, the National Geographic Society and the National Education Association plus many others of similar nature.

The proposed new ruling is apparently based on an act of Congress of 17 years standing which was passed for the purpose of cancelling the tax-exempt status, for one instance, of a macaroni factory which was wholly owned by a university and which was in competition with tax paying corporations.

Senator Vance Hartke spoke in the Senate on June 12 to call attention to the apparent attempt of the Service to "rewrite the law" or to reinterpret the law after a 17-year lapse during which Congress had not seen fit to alter the law.

Senator Hartke emphasized the intimate relation which exists between the publications and the basic purpose of such an organization as the Boy Scouts. He likewise pointed out that a medical journal contains advertising, usually relating to the new drugs, which is highly educational in nature. The senator was not able to find, in either example, any justification for the notion that the two entities, the magazine advertising and the purpose of the organization, are anything but very closely related.

He proposes to air the matter before the House Committee on Ways and Means and the Senate Committee on Finance.

Guest Editorial

Patient Selection for Coronary Care

"THUS it is the lot of a doctor always to be defeated ultimately. His victories are at best reprieves. He can never finally conquer death. Not only small

skirmishes but whole campaigns can be won in this cold war.”**

In the establishment and maintenance of an Intensive Coronary Care Unit, the physician girds up his armor again in the unceasing battle against his implacable enemy—death. The Bethesda Conference of the American College of Cardiology estimated that as many as 45,000 coronary patients will be saved each year when coronary care units are established in the larger hospitals in the United States.

One of the first attempts at resuscitation of an arrested heart by external pressure on the chest was carried out on a President of the United States. Assistant Army Surgeon Charles A. Leale, who was in attendance on Abraham Lincoln at the time of his death, described a form of external cardiac massage used on the President.

“... I also, with the strong thumb and fingers of my right hand by intermittent sliding pressure under and beneath the ribs, stimulated the apex of the heart and resorted to several other physiological methods. We repeated these motions a number of times before signs of recovery from the profound shock were attained; then a feeble action of the heart and irregular breathing followed. I... became convinced that something more must be done to retain life. I leaned forcibly forward directly over his body, thorax to thorax, face to face, and several times drew in a long breath, then forcibly breathed directly into his mouth and nostrils, which expanded his lungs and improved his respirations.”

This superb description by Leale is a brilliant account of resuscitation and illustrates a remarkable understanding of the problem 100 years ago. It is, with some additional sophistication, this method which we teach our nurses in the coronary care unit for the salvaging of lives and hearts and brains.

** William Bean in an essay entitled “On Death.”

A coronary care unit is a highly specialized intensive care unit. At first it was thought that only patients with a complicated myocardial infarction needed this precise type of therapy. Zoll, however, has shown the value of monitoring and of providing immediate resuscitation procedures for “those patients who are doing rather well, who have not suffered a major myocardial damage and loss of muscle, but who may die as a result of a fatal arrhythmia.”

Imboden has also stated that “cardiac arrest and lethal arrhythmias occur at least as frequently in the so-called mild case as in the severe case, and perhaps, more often.”

Regardless of the degree of severity, more than 75% of all patients with myocardial infarction exhibit significant arrhythmias during their course of illness. It is the arrhythmia deaths we want to prevent. For it appears that this complication alone, directly or indirectly, is responsible for death in 30% to 40% of all patients who die of acute myocardial infarction in hospitals.

Therefore, all patients with known or suspected myocardial infarction should be admitted to the coronary care unit. As our experience with the care of severe cardiac disease increases, we find that coronary care units are also admitting cases of serious arrhythmia without antecedent coronary occlusion. Patients who have pacemakers installed may also benefit by being monitored continuously for a few days.

Approximately 85% of deaths in acute myocardial infarction take place during the first ten days of the illness. It appears from present information that the most preventable deaths will occur by the fifth day or at the latest the seventh day. Meltzer has shown that 60% of all deaths from myocardial infarction happen in the first 72 hours.

Day has reported that five days appears to be the optimal monitoring time since 95% of all deaths and unexpected arrests transpired within

this period. Even from a research and investigative point of view, Zoll stated that after ten days, monitoring ceases to provide clinically profitable information.—**A. D. Dennison, Jr., M.D., Indianapolis.**

Editorial Notes...

Most interns now choose hospitals with major medical school affiliations. Since 1953, the percentage of interns matched by the National Intern Matching Program for service in affiliated hospitals has risen from approximately 44% to 60%, while the percentage of matchees going to nonaffiliated hospitals has fallen from about 35% to 25%. During the same time, the proportion of interns going to minor teaching hospitals and the federal service has remained the same.

Indiana exceeded by far all the other states in fatalities from tornadoes in the four-year-period 1962 to 1966. The two tornado belts, the deep south and the mid-west, suffered the most and Indiana reported more deaths (139) than any two of the four high fatality states. The biggest day for losses was April 11, 1965, with 282 deaths in the east-north-central area of states, and with about half of these deaths in Indiana alone. During the four years, Mississippi was second to Indiana with 69 deaths, Michigan had 65, Ohio 63 and Florida 29. Kansas, the state which reputedly has a cyclone cellar with every house, recorded only 21.

The solid waste disposal problem is big enough and tough enough to warrant the creation of a Ph.D. program for its solution. Six institutions of higher learning in the U. S. now offer masters degree level instruction, and recently the Public Health Service awarded a \$38,050 grant to the Uni-

University of Kansas to establish doctorate degrees in disposal technics.

Pharmaceutical manufacturers have vainly sought detailed information concerning the FDA survey of drug potency which allegedly found that 7.6% of all drug samples exceeded the allowable deviation in potency. The FDA, at one time, declined to furnish details on the grounds that the official decision was not to publicize the alleged shortcomings. However, reference to the survey and its uncomplimentary results has appeared time after time in Congressional speeches and in news articles. Those manufacturers who ascertained what products were involved have done careful analyses and had the findings checked by independent laboratories. One percent of the samples were found to be under standard potency. Until recently, at least, the Pharmaceutical Manufacturers Association had not been informed. Its president Joe Stetler remarks "Isn't it fair to require that an agency which demands the truth deliver the truth?"

How to dispose of solid wastes without polluting the air will be investigated at San Francisco. The U. S. Public Health Service has granted \$117,000 as a starter for an expected \$760,000 expenditure for a highly efficient incinerator which will burn the garbage so completely as not to contaminate the atmosphere. The location was chosen because the San Francisco area lacks suitable sites for land-fill projects and because San Franciscans want to stop dumping in

San Francisco Bay.

Radioactive isotopes may be used to test density and moisture content of soil by measuring the rays that are reflected. The Purdue "Background" reports that this is an important test to be done just prior to the laying of modern type concrete roads: the earth foundation of the road must be of proper density and wetness to constitute a good base. "Old-fashioned" lab methods require two hours: a nuclear device produces the information in ten minutes. The time is important since modern road paving is a continuous method made considerably more expensive if the equipment is subjected to stops and starts.

Longevity is on the increase. In a ten-year span ending in 1961, the expectation of life at age 65 increased in Indiana from 12.8 to 12.9 for males and from 15.0 to 15.3 for females. The United States as a whole increased from 12.8 to 13.0 for males and for females from 15.0 to 15.9. The expectation for males in the U. S. is exceeded by males in Canada, Denmark, Israel, the Netherlands, Norway, Sweden and Switzerland. That for females in the U. S. is exceeded, in this same group of countries, only by Canada, the Netherlands, and Norway.

VA research has fashioned a "reading machine" which scans a printed page and emits audible sounds of varying pitch which the user, after training, can interpret as letters and words. Harvey Lauer, a blind VA employee, is able to "read" about 30 words a minute. He can easily distinguish between the sound of one, five and ten dollar

bills, and says that the tens sound best. Lauer remarked that the machine is making Victor Borge's audible punctuation marks a reality.

Opposition to the inclusion of the cost of prescription drugs for Medicare patients is demonstrated by a poll of the nation's independent business proprietors recently. Sixty-six percent of those polled in Indiana expressed disapproval and 64% nationwide registered opposition. The increased cost of Medicare and higher payroll taxes as well as a disinclination on the part of business to grant the Federal government price-fixing powers probably accounted for the overwhelming opposition.

In World War I it was called "trench foot" and was thought to be caused by soldiers standing in cold, wet trenches. In the jungle fighting in World War II, it occurred in warm weather where there were no trenches and it occurred again in the Korean conflict in all kinds of weather. There wasn't much that could be done about it until recently. Silicone grease has been used in recent testing. When troops spread it liberally on their feet and socks, it was found they could endure wet feet for several days without suffering the painful condition known today as "warm-water-immersion foot."

A disposable emergency oxygen unit is now available for elderly and convalescent patients. There are two sizes, 58 liter and 22 liter. The units are lightweight and can be easily self-administered. The larger size will provide a 25-minute supply of oxygen with the valve kept continuously open. They are easily portable and can be kept in home, office, car or boat. ◀

Meet The Journal Staff



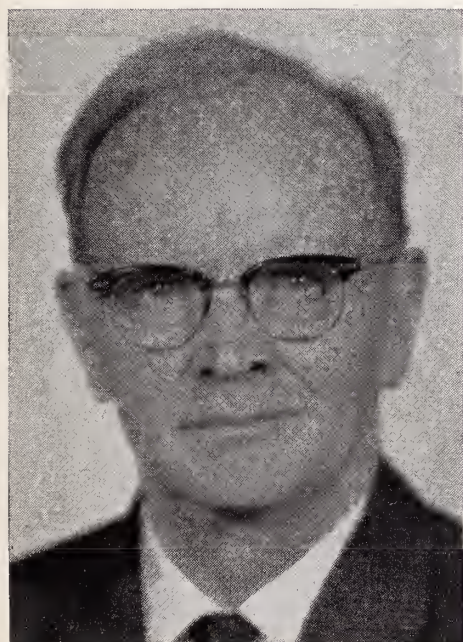
DR. CAVINS

Alexander W. Cavins was elected Associate Editor of *The Journal* in 1949. He is engaged in the active practice of gynecology in Terre Haute, is a member of the active medical staff of the Union Hospital and is a courtesy staff member of St. Anthony's Hospital.

Dr. Cavins was graduated from Shortridge High School of Indianapolis and was awarded the A.B. degree by Butler University before attending medical school at Johns Hopkins University. During the process of obtaining the M.D. degree, he also attained membership in Phi Beta Kappa, Sigma Xi and Alpha Omega Alpha.

His postgraduate hospital training was taken at the Hartford Hospital, Hartford, Connecticut, in the years 1925 to 1927. In June, 1927 he entered the practice of surgery, obstetrics and gynecology in Terre Haute and later specialized in gynecology. He is a Founding Fellow of the American College of Obstetrics and Gynecology, and was certified by the American Board of Obstetrics and Gynecology in 1943.

Dr. Cavins is a Fellow of the American College of Surgeons. He is member and past-president of the Indiana Obstetrical and Gynecological Society. He is also a member of the Terre Haute Academy of Medicine, the Aesculapian Society of the Wabash Valley and the Johns Hopkins Medical and Surgical Association.



DR. LYNCH

Dr. Harold D. Lynch has been a member of the Editorial Board of *The Journal* since 1953. At the time of his selection to *The Journal* staff he was in the full-time practice of pediatrics in Evansville. Since retiring from private practice, he has served as Associate Medical Director from 1961 to 1963 and as Project Director, Medical Affairs, from 1963 to 1966, for Mead Johnson Laboratories. He is now a staff physician for the Evansville State Hospital.

Dr. Lynch was granted two degrees by Indiana University, the B.S. in 1923 and the M.D. in 1926. His intern and residency training was received at Philadelphia General Hospital, the Philadelphia Hospital for Contagious Diseases and St. Christopher's Hospital for Children from 1926 to 1929.

Dr. Lynch is a Fellow of the American Academy of Pediatrics and was state chairman for Indiana for the Academy from 1951 to 1957. He is a Diplomate of the American Board of Pediatrics and a Fellow of the American College of Physicians.

He is a member of the American Medical Writers Association, has written extensively on the subject of nutrition in children for medical periodicals and for the *Yearbook of Pediatrics*, and has authored an out-

standing popular book entitled "Your Child Is What He Eats." He is also a contributing author for H. C. Shirkey's *Pediatric Therapy*, published in 1964 and revised in 1966.

Dr. Lynch is a medical staff member of St. Mary's Hospital, Protestant Deaconess Hospital and the Wellborn Hospital, and is a member of the Board of Managers of Boehne Tuberculosis Hospital, all of Evansville.

In 1964 he supervised and directed the production of an educational filmstrip on phenylketonuria for Mead Johnson & Company. He served as a member of the Evansville-Vanderburgh County Health Department Board from 1952 to 1955 and was its president in 1955. In 1954 he was president of the Indiana State Pediatric Society.

President's Page

Dear Doctor:

Most of us have had our vacations and returned to work. It seems to me that the work we have outlined for us the next several years is preserving the free enterprise system of America. The doctors of medicine in America are the front line troops against creeping socialism. If we allow our profession to be completely socialized, the whole United States will go the same way. The social planners are constantly at work.



You and I do not spend enough time at it. I overheard a conversation that James Waggener had with another individual in which he stated, "Supposing all the doctors band together and refuse to do this particular task that the man wanted done?" The man's answer was, "Jim, you don't have that kind of glue." Another remark I have heard recently is — that one of these days the doctor is going to wake up and read in the morning paper that his fees for office visits and house calls have been set by the federal government.

Perhaps the doctors of medicine should quit forming an association and form a union. Are these the statements of people who are just alarmed? No, these are statements that are made daily. These are the statements of fact. You and I cannot just resist socialism, we must actively fight it. We cannot always be just against something. We must be for something.

With technical advances and computers, our world is changing rapidly. We cannot expect to practice medicine the same old way for the next 100 years. We cannot say that problems do not exist when deep in our hearts, we know they do. We must look for the problems in health care, and we must correct the errors and the ills of our method of care.

If we do not do this, we are opening ourselves to more federal control. We must support our organizations and we must, also, serve them. The officers of the state organization do not have all the answers — in fact they do not have enough answers. Send your best men to the Council table; send your best men to the House of Delegates. Be willing to sacrifice some time, and perhaps some money; be willing to be stout hearted; be willing to take abuse; be willing to fight for the right.

Eugene S. Rifkin M.D.

Night Leg Cramps . . . Unwelcome Bedfellow In Diabetes,¹ Arthritis,² and Peripheral Vascular Disorders²

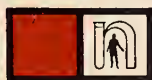


now . . . specific therapy for night leg cramps

Walker

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

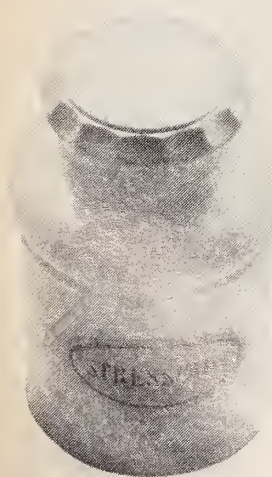
Prescribing Information: **Composition:** Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



in alcoholism:

B and C vitamins aid therapy. Therapeutic amounts of B and C vitamins can be important in the management of the alcoholic patient. In alcoholism, as in many chronic illnesses, STRESSCAPS vitamins aid therapy.



Stresscaps[®]

Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (as Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

691-6-3942



The Woman's Auxiliary

REPORTS TO ISMA

One thousand and fifty-two physician's wives registered at the 44th Annual Convention of the Woman's Auxiliary to the American Medical Association. The meetings for the ladies were held at the Shelburne Hotel and were well attended. We were happy to have as guests two Vietnamese students (young ladies) who had just completed three months specialized medical training at Georgetown University. Part of their living expenses were paid by auxiliary sponsors.



Sunday evening many of us attended the AMA session "The Doctor's Dilemma in the World of Changing Morals," sponsored by the AMA Committee on Medicine and Religion.

Monday our meetings officially opened. The Indiana ladies who served as auxiliary delegates were: Mesdames Lester Bibler, Frank Gastineau, E. Bruce Kephart, Alfred Scales, Jack Eisaman, G. O. Larson, Eugene Rifner, Kenneth Neumann, Jay Reese, William Tindall and John Deever. It was wonderful to have a full delegation.

Dr. Mary Calderone, Director of Sex Information and Education of the United States, spoke at our Tuesday morning session. Her topic was "Goals and Means." So many persons requested copies of her talk that our national auxiliary decided to print it in our magazine *M.D.'s Wife*. This article will be worth reading by both you and your wife.

Charles Hudson, M.D., AMA-president, spoke at the luncheon meeting honoring auxiliary past-presidents. His subject was "The Women — Bless 'Em." (Of course all of the ladies agreed with him 100%.)

The national auxiliary was proud to present to the AMA a check for \$384,649 for the AMA Education and Research Foundation. This gift was through the combined efforts of all state auxiliaries. Once again, Indiana was the recipient of a plaque, an award to the state for raising the largest amount of money in our membership category. Indiana's contribution was \$19,124; our membership totals 2,874.

Another speaker who was quite well received was Miss Evelyn Dubrow, legislative representative for the International Ladies Garment Workers Union. Our sessions closed with a "round-up report" on the AMA House of Delegates activities, presented by Ernest Howard, M.D., AMA assistant executive vice-president.

Much time and effort goes into the planning of such excellent meetings: it is too bad more people do not avail themselves of the opportunity to attend.

Roberta P. Deever

The Doctor is Losing His Voice^{*}

PAUL HARVEY
ABC News Commentator
Chicago, Ill.

GOOD afternoon, Americans. You know medicine. I know something about socio-economics and much about public information.

Let's help each other.

In Britain, where "government medicine" has a head start on us, *you may have to wait seven years for surgery!*

In the United States, our Social Security taxes increased by a billion dollars this year. Even if there is no further expansion of this program, the cost in taxes will continue to increase over the next ten years.

Before the politicians of this Congress bait their hooks with any more "free medicine," we should study Britain's experience very carefully. It makes no sense knowingly to follow a blind leader into a ditch.

The British people are drifting back toward private health insurance. British United Provident Association privately insured the health of 73,000 Britons in 1950. But in 1960, they had covered 775,000. As of last year, this one Association was insuring the health of 1.2 million Britons.

Or take Prudential of London. Its private health insurance subscribers have multiplied 15 times in 15 years, doubled again in the past five years.

The reasons that four million Britons now pay for National Health Service through higher taxes—but *pay extra* for private medicine—are the long waits for surgery and the hurried, impersonal examinations by NHS doctors.

The average United States doctor sees 169 patients in his office every week. In Britain, an NHS "govern-

ment doctor" is expected to see 600 in a week!

The Wall Street Journal's Roger Ricklefs says a private patient in Britain may check into any hospital for any operation almost immediately. A state patient may wait six months or a year for non-emergency surgery. And for such things as hernia and varicose vein operations, he may wait seven years!

A typical patient who now pays extra for private treatment, Peter Dukes, Birmingham printer, 28, says, "I decided it's worth it to pay a bit."

And Peter Dukes' private doctor, Gilbert R. Smith, explains why he quit the welfare state medical system entirely:

"Under the National Health Service, it's practically impossible to practice medicine the way I like to work. I cannot give a proper examination in ten minutes, but when you have 35 patients in the waiting room, you are dominated by the thought of getting each examination over with in a hurry."

So from yet another example, we can see that socialism creeps backward as well as forward. Unfortunately, by the time the fallacies of "free medicine" are recognized, the people are already saddled with an overburden of taxes and it becomes almost impossible to dislodge the bureaucracy which feeds itself from that source.

"Government medicine" has proved to be potent vote bait in the United States—as it did in Britain. But it disguises a barbed hook.

The Man Who Isn't There

When there are no maids available, we can "make do." When gardeners are in short supply, Junior can handle the chore. When car washers

are not available, we automate that task.

But when we cry out in the night for a doctor—and get no answer—we're in trouble.

Our Government is promising to spend much of our money on medical services, but *money cannot buy services which don't exist!*

It makes no difference how elaborate the politician's promises for Medicare, it cannot deliver what is not there.

President Johnson has projected elaborate, expanded plans for providing for the medical needs of everybody, from infancy through old age. He expects to get the money from us.

But where will he get the doctors?

In 1940 there were 350 doctors for every 100,000 American children.

Today there are only 150 doctors per 100,000 children!

Surgeon General Dr. William Stewart says, "Children today are receiving less medical care than they did 26 years ago. As a result, the infant death rate is increasing. Already 14 other countries have lower baby death rates than the United States!"

So Bethesda is now instructing Navy wives in how to examine their own children; a "do-it-yourself clinic."

And while the number of Americans of all ages is increasing, the number of physicians is proportionately decreasing.

"Who wants to spend 12 years studying to become a bureaucrat?"

Trying to shift the burden to nurses doesn't work, because there's a chronic shortage of available nurses, too.

Dr. Jerome Schulman, Chief of the Department of Child Psychiatry at Children's Memorial Hospital, Chicago, says the mentally ill are the most woefully neglected.

"Of our nation's 1½ million hospital beds, half are occupied by mental patients. Each psychiatrist

^{*} Remarks given at the 23rd Annual Conference of Presidents and Other Officers of State Medical Associations, June 17, 1967, Atlantic City, New Jersey.

could right now have 750 patients in hospitals.”

Available hospital space must be reserved for the most acutely ill; thus, for every patient now in a mental hospital, *ten should be*.

And the situation is worsening.

Unfortunately, many Americans construe campaign oratory for fact. Under Medicare, the fact is that the Government does not guarantee a hospital bed, it does not guarantee a doctor. It cannot. Government merely undertakes to pay most of the bill. There is no Federal obligation to supply services—just money.

And money cannot hire the man who isn't there.

Figuratively, Government has invited a hundred thousand people to a barbeque when there is food for only one thousand. Yet many members of Congress sought re-election last fall by inviting more voters to partake of this meatless meal. Most will go home hungry, but the politician figures he can conjur up some jucier bait before the next election.

Until eventually, as in Britain, one after another of these “free services” is withdrawn, while the increased taxes go on and on and on

We Can Kill with Kindness

We can kill with kindness you know. Whenever I see Americans standing in line; whenever I see Americans demonstrating, demanding more Government handouts, I am re-reminded that we can, in fact, kill with kindness—that “good intentions” are not enough.

The Paul Harveys have lived recent years with a very painful, personal, daily reminder of this fact.

We over-fed our toy poodle on the sweets which the little fellow begged for.

It is important that you remember this: He did beg for them.

But he developed diabetes and became mostly blind. He failed to respond to oral therapy so every morning, seven days a week, for four and a half years, Angel took him to the

veterinarian for his daily injection of insulin.

We had made him momentarily happy—but we had made him permanently dependent.

But we know so much better than we do—we Americans. So often we know what's right and we go right ahead and do what's wrong because we are not guided nearly so much by how much we know as by how we feel. We know so much better than we do. That's why a lot of pretty good Americans go around preaching free enterprise—and voting for Santa Claus. Because we know so much better than we do.

We know better than to smoke, but we are smoking three billion more cigarettes per year now than before the “scare.”

I'm sorry. I apologize for presuming to expert a medical matter before this audience.

Actually I have been one not too secretly hoping that some of you would discover it's really television that causes cancer. Think about it. Then we could do away with both these evils—television and cancer—and all go back to smoking cigarettes again.

In the event this is being broadcast and before the opposition demands equal time to reply perhaps I should state that the cigarette makers now advise me that they have fixed their product so that it does not cause cancer any more. Thank you.

The only thing is, have you noticed they have now had to make the filter so long you are likely to get a hernia from sucking so hard.

Ethics Unchanged

I have never given carte-blanc endorsement to any individual or any organization.

The individual you endorse today might tomorrow be guilty of some durn-fool, indefensible utterance which discredits himself and friends. The organization, however well intentioned today, might eventually go astray—and there you are with your name on its letterhead.

You can go down the line with principles; those remain unchanged and unchanging.

The principles of medical ethics are today unaltered from the time when they were originally uttered by the Babylonians. The code by which you practice medicine today is unchanged from that of Charoka and Susruta—Hindu writers of unknown antiquity.

Your guidelines were re-enunciated by Christ and specifically defined by Hippocrates. They were restated in the Code of Percival in 1792 and eventually in the various pronouncements of the American Medical Association.

The practice of medicine has changed; the principles have not changed.

And however short we may fall of living up to the image, the ideals which you have inherited must remain uncompromised.

It is noteworthy that 120 years ago, when the AMA was founded, the two paramount items of business dealt with minimal educational requirements and a code of ethics.

Now, if the doctor-patient relationship is to be supplanted by what Aldis called a “patient-committee relationship”—there is danger that historic obligations might become diffused. Allegiance to Government, however subtle, could cause the physician's sense of responsibility to the individual patient to become diluted.

Recently, we laymen have been confused and confounded by hearing men and women of distinction in your profession quoted on matters more political than medical . . . some of them urging that medicine be further socialized, espousing increased Government responsibility for our “welfare.”

It is not as if our Federal Government ignores human need. Care for servicemen and their dependents, aid for the aged, all welfare grants are derived from “tax dollars.” Thirty million Americans are now

getting all or part of their medical care from government.

Yet renowned physicians lend their names to efforts further to provide "government medicine" for our citizens.

Why?

Is it because these doctors are themselves on the federal payroll? Is it because each of these derives part or all of his income from "government grants?"

Not one of the 26 "Physicians for Health Care for Aged through Social Security" is a full-time practicing physician. They are a minute handful of the 200,000 members of the AMA.

Yet, because their names are news, they have influence all out of proportion to their numbers.

A man not in private practice is less likely to be "practical."

In Massachusetts General, Boston's ivory tower, most all research is "government sponsored."

Similarly Western Reserve has benefited from millions in "government grants."

The National Institutes of Health will dole out a billion of your dollars this year to support medical research.

Some medical school's research budgets are 87.6% supported by government.

What I'm saying is that doctors who are on the government payroll, however indirectly, through grants from The National Institutes of Health, the Department of Health, Education and Welfare, the Atomic Energy Commission, etc., have a third allegiance.

Understand, I do not impugn the integrity of these distinguished doctors. I refuse to believe they would sell their convictions for dollars, though the temptation is obvious.

But I am concerned that they allow their reputations in one field to lend undue importance to their advice in another.

Einstein was a mathematical genius and a political dunce.

Who Will Speak for the Doctor?

So—a handful of articulate doctors are self-appointed spokesmen for the rest.

These are mostly men from government subsidized university faculties who are not engaged in the kind of practice which they frequently choose to criticize.

From their ivory towers they contradict a primary ethic of their own profession—they presume to diagnose and prescribe from a distance.

I have never known a dedicated doctor who is opposed to humane care for the aged or the poor, or who shirked his share.

Yet the image of the modern doctor is largely one of heartless, mercenary indifference because—and I say this with considerable respect for the splendid efforts of Dr. Ed Annis—the medical profession has had no grassroots cheerleader since Morris Fishbein.

When medicine had no other spokesmen, he did not let its detractors get away with half-truths.

I don't like to have to wait in line at the doctor's office.

I resent the fact that my doctor does not work 168 hours a week.

I think I'm overworked when I work 11 hours a day, but it seems to me he should work 24.

Until I really think about it. But what's to make me think?

The professional man's contact with the rest of us has been inhibited by his ethics, by his preoccupation and by the fact that he studied medicine so long and works at it so hard there isn't time for much else.

And the doctor doesn't know much else.

He doesn't know about the symptomatic isms which infect the healthiest body politic.

He doesn't recognize the red metastases of the Marxist malignancy.

He doesn't comprehend that the big government which offers to keep us safe from ourselves has straight jackets in mind.

And for the doctor to ignore the

basic laws of economics is as foolish as for a chemist to ignore the laws of valence—and altogether as potentially deadly.

When government takes our taxes to provide for our welfare, it's like a man trying to give himself a transfusion from his right arm to his left.

And when bureaucrats do it, they're likely to spill half of it in the process.

Historical Challenges

Your association is not unaccustomed to challenges and crises.

Apathy was your first adversary. When your AMA was born, two-thirds of all medical colleges ignored the birth.

Subsequently, sectarian medical bodies resisted your efforts. Where today you must fight off those who would bureaucratize your profession, then you had to rise above the do-it-yourself healers, homeopaths, eclectics and cultists. Then, too, you were outnumbered and your own members divided. But the Association held together and worked together and survived—and thrived.

Medical journalism was threatened with disrepute in 1898. There were 275 periodicals on health and disease, only a handful had any merit. But only a handful survived. *The Journal* survived.

In the 1880's the AMA was threatened with disintegration. But when a large group refused to accept the ethical standards of the organization, their membership was cancelled. The code survived. And the AMA survived.

Trying to get Government to prevent the adulteration of foods in the 19th century, you failed, but gained important experience in influencing legislative developments.

By 1900 you knew what NOT to do. And in 1906 you tipped the balance in favor of a pure food and drug act.

And in the 20th century, this organization accepted an influential role in public affairs. With drastic structural reforms in your organiza-

tion, you were responsible for humanitarian, educational and disciplinary reforms a long time before anybody in Washington recognized either as an advantage or a need.

Always uphill . . . against obstructionists—some in your own organization.

Starting in 1910, with your Council on Health and Public Instruction, began the golden years of the AMA's public relations. And from that effort, I believe, evolved the unquestioned supremacy of your Association in the medical profession.

Insofar as possible, I am omitting names of individuals however important they may have been to the emergence of the Association, because we are here concerned with principles, not personalities.

But when I speak of journalism, I am talking about something I do know something about.

The *AMA Journal*—under George Simmons and later under Morris Fishbein—spread the power and influence of the AMA at home and abroad. In addition to being a catalyst for your profession, the journal was a medical authority of unimpeachable stature for the press and the public.

With it you could fight nostrums and quackery and compulsory health insurance and you fought each fight and won them all . . . so long as your voice was loud and clear.

And your voice, technically and editorially, was the journal.

But for most of two decades the doctor has been losing his voice.

Perhaps what has happened since 1949 was an inevitable result of a public grown prosperous and fat, yielding its prerogative to Big Government.

The politician who promised to spend the most of our money on us . . . we voted for.

And there was nobody to talk back.

The doctor is losing his voice.

You doctors are notorious for neglecting yourselves, so it is not going

to be easy to make you adequately anxious about a case of laryngitis.

A Congressional investigation of allegedly over-priced drugs in hospitals is going to reflect discredit on the medical profession per se.

The headlines say, "One Dollar for Two Aspirin to Captive Customer."

To suggest that the AMA might have ventilated this situation before the stench accumulated is to quarterback yesterday's game.

But that there has been inadequate liaison between the profession and the public is obvious.

Someone representing medical interests must answer headlined indictments with equal boldness.

The Doctor is Losing His Voice

In handling medical matters, the press characteristically tends to underscore the sensational.

Sometimes we can't help it.

A false alarm may be unavoidable in the instance of a novice researcher prematurely excited about some imagined breakthrough. Also, we shall always have with us some physicians who are less reluctant than others to focus attention on themselves with dramatic utterances.

But the greater risk to the public and to the profession derives from a misleading public statement on matters of medical ethics, philosophy and principle.

A news analyst cannot possibly be an authority on every subject which he is required to discuss. Generally, therefore, we come to rely on the counsel of experts in each field.

In a matter involving some facet of space flight, there are acknowledged spokesmen for both government and industry.

In most other physical sciences, it is comparatively easy to seek and find and consult with an official or quasi-official spokesman.

Big Steel has a spokesman; so do the steelworkers.

In sports we take our questions to the persons with the best batting average. We ask questions on military weapons and tactics of military

specialists whom history has proved right more often than wrong.

But in the urgent policy matters relating to medicine, where can we go?

Recently and presently the news media have most often accepted as "the last word" the word of the Surgeon General of the United States.

I do not believe the surgeon general, however capable he may be, is the proper person to speak for the medical profession. He is a bureaucrat, necessarily parroting the party line of any incumbent political administration.

Recently, in such sensitive areas as federal money for private medicine, expanded social security, trade-name versus generic drugs, participation versus non-participation in Medicare, direct billing versus assignment, certification of medical necessity for Medicare and Medicaid, drug costs and hospital rates, areawide planning for hospitals, utilization review committees, the news media have been brainwashed with the "Government" point of view—because modern medicine has no other effective voice.

I say what I am saying with much respect for Dr. Blasingame whom I have sought out for guidance or a statement on some of these issues. But his prerogatives in enunciating socio-economic policy are presently hopelessly restricted.

Since the old jam-packed press conferences where the *AMA Journal* editor would announce the AMA diagnosis, prognosis and prescription in matters of national interest and public policy—the image of the medical profession has become blurred or blackened.

In respectfully recommending that the AMA again figure out some way effectively to speak through someone with one voice, I am aware of the risk involved. The spokesman might turn out to be a believer in the Big Government philosophy.

But I am willing to take that risk, because he can't be any further left than a politically appointed surgeon general.

Every night at six, an audience of forty million viewers is available to some articulate, uninhibited, preferably wavy-haired medical statesman-spokesman. And every night you don't supply one, the Government does.

Now . . . even in a terminal illness prognosis we would be careful to maintain what Dr. Paul Rhoads calls, "Honesty tempered with optimistic uncertainty."

Indeed, I am unconvinced that ours is, in fact, a hopeless case.

Today's youngsters are exposed to trigonometry in Junior High School. By the time they are voting age they will know that two and two are four.

When they know this, tomorrow's politicians should not be able to sell them the Ponzi promise which they sold you and me; the promise that we can all stand in a circle with our hands in each other's pockets and somehow get rich thereby.

When they have studied biology, physiology . . . how are tomorrow's politicians going to sell them the foolish notion that all everything's are created equal, when in fact no two anythings are?

And when they have re-read history, will they not surely learn that great nation states never spend them-

selves rich. Inevitably they spend themselves poor.

I respectfully suggest that tomorrow's politicians had better start getting ready for a generation of voters who are going to be smarter than we were.

But just smarter is not enough. Just taller, and handsomer and healthier and more capable is not enough if they have lost that "old fire in the belly" which characterized their granddaddies.

We're telling our young people that being an American is worth dying for and, what is sometimes more difficult, worth working at. They want to know if it is worth it. I think they are entitled to an answer to that question.

As we say in the Missouri Ozarks, "let's shuck right down to the cob." Just how indelible would your patriotism and mine have been if during our formative teen years our government had told us we might have to go 6000 miles away to fight communism but if we try to fight it 90 miles from Florida we'd be thrown into jail.

Just how red, white and blue would you and I have been if we'd been reared in an hour when our Government penalized those who tried to prosper in order to subsidize laziness

and lethargy and illegitimacy.

How enthusiastically would you salute Old Glory if you have been sent off to fight foreign wars under a mongrel flag—wars which we appear ashamed to lose and afraid to win.

I'm not excusing the young demonstrators but I am capable of comprehending their frustrations and I am willing to accept part of the responsibility for it.

Because we in the press too often look at their future through the wrong end of the telescope. We focus attention on the misfit and the off-beat and the exceptional. We underscore ugliness.

But for the same reason the coach reviews the errors in last week's game; so that his team won't make the same mistake again.

So this afternoon I have focused attention on one debit midst a century of credits.

Please don't misunderstand this critique.

You have managed such medical progress in your lifetime that we and our children can expect additional useful pain-free years of life itself!

You gave us that!

We are forever in your debt. Now—*help us* who so respect you—to *help you in every way we can.* ◀

New Film Available

A new addition to the AMA's film library is "Diseases of the Gallbladder." This 12-minute, color, sound film, prepared by Hilger Perry Jenkins, M.D., Chicago, shows the varied nature of gallbladder disease as seen in the operating room, the surgical pathology laboratory and, in one instance, the morgue. A dozen cases are briefly presented to illustrate small and large gallstones, hydrops, empyema, gangrene, external fistula, carcinoma, adenomyoma and duplication. There is a \$3.00 service charge for this film.

News from Indiana University School of Medicine

A special training program for registered professional nurses that will make intensive care available to more Indiana citizens suffering from acute heart attacks will be offered by the Indiana University School of Nursing.

The new program represents an additional means for quicker translation of the latest medical knowledge into benefits for the patient, Dr. Kenneth E. Penrod, provost of the I.U. Medical Center at Indianapolis, said.

Miss Emily Holmquist, dean of the school of nursing, reported that a grant of \$80,474 would be used to set up a program to increase knowledge and skills of professional nurses in order to provide expert care for heart attack patients in specialized coronary care units. The course has been developed in response to a need expressed by hospitals throughout the state, she said. According to figures recently released by the State Board of Health, heart disease was at the top of the list of the 10 major causes of death in Indiana in 1965, nearly equaling all the other major causes combined.

The grant was made to the school of nursing by the U.S. Public Health Service through the National Center for Chronic Disease Control. Miss Jean Schweer, associate professor of nursing and director of continuing education for the school, is director of the program. Trainees for each course will be selected according to priority needs, giving first preference to nurses nominated by hospitals operating or planning to operate coronary care units, Miss Schweer said.

(In a recent survey, 59 Hoosier hospital administrators said that they needed this type of training program

for four or five of their nurses, and 27 hospitals now without coronary care units will install them when trained nurses are available.)

Many Indiana hospitals with established coronary care units are providing in-service education programs for their own personnel, but these programs are not open to outside nurses, Miss Schweer pointed out. The Indiana Heart Association has offered a variety of programs and consultation visits to nurses in Indiana through its Nursing Education Committee, and has been the moving force in establishing assistance for nurses in coronary care units, she said. Therefore, she continued, the heart association and the school of nursing organized a joint planning committee to design the projected program.

The actual course was developed by Mrs. M. Jeanne Pontious, assistant professor of nursing, and Miss Schweer in cooperation with Dr. John B. Hickam, chairman of the Department of Medicine, Dr. Charles Fisch, professor of medicine, and Dr. Harvey Feigenbaum, associate professor of medicine at the I.U. School of Medicine.

The four-week program, limited to 18 students per course, will be repeated four times a year. Each student will be expected to achieve proficiency in recognizing normal and abnormal patterns of heart rate and rhythms, and the interpretation of cardiac monitoring systems. The students also will be expected to develop and utilize a nursing care plan for each patient for whom they are responsible. Laboratory facilities at Indiana University and coronary care units at Marion County General Hospital and at Community Hospital will be used.

Qualified physician and nurse faculty members will be responsible for the course. Designated nurse preceptors will supervise the clinical nursing experiences in the cooperating hospitals.

Patients in the coronary care units are hooked up to machines that continuously record their heartbeats on small, round screens, and sound alarms when irregularities occur. The machines are monitored continuously by the nurses, who are taught to interpret the electrocardiograms and how to act in emergencies. Other equipment with which they must be completely familiar includes such instruments as the external pacemaker, which may start up a stopped heart and keep it operating; the defibrillator, which can smooth out an irregular heartbeat; the automatic rotating tourniquet machine, the electrocardiograph machine, respiratory resuscitative equipment and drugs for general and emergency use.

Plans for the I.U. School of Nursing course include a follow-up evaluation visit at the conclusion of the project to obtain information about trainee performance on the job. The quality and effectiveness of an in-service training program for other nurses developed in the local situations by the trainee will be a major item of evaluation. Follow-up consultation visits will be made upon request from trainees.

The school of nursing offering has even greater significance in view of the Regional Medical Program Planning Grant recently made by the National Institutes of Health to the I. U. School of Medicine, Dr. Penrod said. One portion of this nearly \$1 million program will deal with exploring the requirements in facilities, personnel, training centers and funds

to establish and maintain a network of coronary care units accessible to all persons within the state. A feasibility study for providing emergency diagnosis and intensive coronary care in isolated areas by making use of specially trained nurses or physicians' assistants in communication with a central medical consultant group by closed circuit television and telephone line transmission of electrocardiograms and other data also is included. The objective is to make available to every Hoosier, regardless of where he may reside, the very latest and best care available for the heart attack victim, Dr. Penrod declared.

A communications network envisioned in the Regional Medical Program may be used in the future for nurse training programs in coronary care units, as may programmed instruction and multi-sensory approaches now under investigation by the school of nursing. ◀

How To Go To Sleep

Let us all remember that we must not prescribe just the dosage that is given in a book; we must give enough to produce the effect we desire. Also we must not rigidly prescribe a dose every four hours; it is better to tell the nurse to give enough of the medicine to relieve pain, and when the pain returns to give another dose.

I learned much pharmacology years ago when I watched a man quickly drink four martinis. He explained that he did not feel anything until he had four. And then I thought of the many times I had wondered why a man like that had to take three or four capsules of a barbiturate before he felt sleepy.—Walter C. Alvarez, M.D., in *Modern Medicine*, (34:106), March 14, 1966.

Tandearil® oxyphenbutazone

Tandearil in Painful Shoulder

Therapeutic Effects: Stiffness and pain may diminish within 2 days, and full mobility may be restored within a week. These effects are obtained with oxyphenbutazone alone or combined with physiotherapy or local hormonal injections. The drug is usually well tolerated and does not affect pituitary-adrenal function or immune response.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage. Make regular blood counts. Discontinue the drug and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, or a generalized allergic reaction may occur and require withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Painful Shoulder: 600 mg. daily in divided doses for 2 to 3 days; 300 mg. daily thereafter. Usual duration of therapy: 2 to 7 days.

Availability: Tablets of 100 mg. 6562-VI(B)R

For complete details, please refer to full prescribing information.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

Geigy

Tandearil®
oxyphenbutazone

helps painful shoulders
move again



3 out of 4 painful shoulder patients
responded well

84.2% of 127 patients

81% of 48 patients

Please see ad-
joining page for
brief prescribing
summary.

TA-5094PC

Sperling, I. L.:
Applied Therap. 6:117,
1964.

Rosenbaum, E. E., and
Schwarz, G. R. North-
west Med. 61:927, 1962.



at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food¹⁻³

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.^{1,2} Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.^{1,3}

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels

attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:

New! Ready-mixed Ilosone Liquid 125!
(Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

Ilosone®
Erythromycin Estolate



(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticaria, skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours. (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: *Am. J. M. Sc.*, 247:69, 1964.
2. Griffith, R. S., and Black, H. R.: *Antibiotics & Chemother.*, 12:398, 1962.
3. Hirsch, H. A., Pyles, C. V., and Finland, M.: *Am. J. M. Sc.*, 239:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Report on Actions of the House of Delegates

American Medical Association 116th Annual Convention June 18-22, 1967 Atlantic City, New Jersey

THE House of Delegates of the American Medical Association set two records at its recent meeting in Atlantic City, New Jersey.

One was attendance. After 95% of the authorized delegates attended the Sunday, June 18, opening session, 100% — 242 delegates out of 242 — were in their seats for both the Tuesday and Wednesday deliberations. Thursday, the final day, attendance still stood at 240.

The other was accomplishment. All told, the House was presented with 151 items of business on which action had to be taken, including a record total of 123 resolutions from state medical associations; 18 reports from the Board of Trustees, three of which were nominations to fill Council positions; four reports from the Council on Medical Service; three reports from the Council on Constitution and Bylaws, one produced during the convention in order to implement an adopted resolution; two reports from the Council on Medical Education; and one report from the Judicial Council nominating affiliate members of the Association.

The Indiana delegates were in attendance 100% and as one of them put it, "batted" 1000 in the introduction and passage of Resolution 103 which dealt with drug dispensing provisions under Title 19.

Passage, however, was accomplished over the obstacle of the reference committee report which gave the resolution a "no" vote.

Speaking to the point, Dr. Maurice E. Glock, alternate delegate from Fort Wayne, opened debate in the House of Delegates on the reference committee action and the Indiana resolution was reinstated by a large

majority.

Following is the text of the resolution: "Whereas, In the Handbook of Public Assistance Administration, Supplement D, 5150, dealing with Medical Assistance Programs under title XIX of the Social Security Act reads as follows:

'Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the definitions, items 1 through 15, in D 5141 (also see D 5800)

'Drugs — with respect to 'prescribed drugs' as defined in D 5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists, and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof,'; and

"Whereas, This policy statement is to be proposed as a regulation; and "Whereas, This tends to delimit the right of the physician to dispense drugs, increase his paperwork and leave an avenue open for argument as to who will define 'where no adequate pharmacy services exist or are available when needed'; therefore be it

"Resolved, That the American Medical Association voice its strenuous objection to the policy as enunciated in the Handbook and seek its removal as a policy and a possible regulation for dispensing drugs under Title XIX."

The delegates, alternate delegates, members of the Executive Committee and officers of the ISMA diligently represented the association at the convention and planned each day's activity at a 7 a.m. breakfast.

Dr. Lester H. Hoyt, Indianapolis, assistant treasurer of the ISMA, was elected chairman of the AMA's Section on Pathology and Physiology for 1967-1968.

Immediately following the convention, the Board of Trustees of the AMA, in a reorganization meeting, elected Dr. Lester Bibler, Indianapolis, to the executive committee of the board.

Dwight L. Wilbur, M.D., San Francisco, Cal., was elected president-elect of the AMA. Dr. Wilbur has been a member of the Board of Trustees since 1963. He will serve in his new capacity for one year and will be installed as the Association's 123rd president at its annual convention in his home city in June, 1968.

Malcom E. Phelps, M.D., El Reno, Okla., who has been field director of the Volunteer Physicians for Vietnam program, was elected vice-president of the Association.

Walter C. Bornemeier, M.D., Chicago, Ill., was re-elected Speaker of the House and Russell B. Roth, M.D., Erie, Pa., was re-elected Vice Speaker of the House.

Four trustees were elected to succeed themselves: Wesley W. Hall, M.D., Reno, Nev.; Irvin E. Hendryson, M.D., Denver, Colo.; Alvin J. Ingram, M.D., Memphis, Tenn.; and Robert C. Long, M.D., Louisville, Ky.

Edward R. Annis, M.D., Miami, Fla., was elected to complete the term on the Board of Trustees vacated by the death of Homer L. Pearson, M.D., Miami, Fla.; and Burt L. Davis, M.D., Palo Alto, Cal., was elected to complete the term as trustee vacated by the resignation from the Board of President-Elect Wilbur.

Thurman B. Givan, M.D., Brooklyn, N. Y., was elected to succeed himself on the Council on Constitu-

tion and Bylaws.

Earle M. Chapman, M.D., Boston, Mass. (succeeding himself), and Vernon E. Wilson, M.D., Columbia, Mo., were elected to the Council on Medical Education.

George W. Slagle, M.D., Battle Creek, Mich., was elected to succeed himself on the Council on Medical Service.

On the nomination of President Rouse, Elmer G. Shelley, M.D., North East, Pa., was elected to succeed himself on the Judicial Council.

The American Medical Association's Distinguished Service Award was presented by the House of Delegates to E. W. Alton Ochsner, M.D., of New Orleans, La.

At Sunday's opening session, the House heard outgoing President Charles L. Hudson, M.D., Cleveland, Ohio, urge physicians of the United States to "take the initiative and apply local solutions to local problems" in order to "persuade people that the proper function of government is to confine its activities to the support of private enterprise rather than to act as a competitor." Dr. Hudson stressed that it remains a continuing charge of physicians "to seek out and meet any discovered needs for health care" and observed that "One of the greatest challenges facing the medical profession now and in the immediate future . . . is the organization of community health care."

At his Tuesday evening inauguration as the Association's 122nd President, Milford O. Rouse, M.D., Dallas, Tex., followed a similar theme in pointing out that "The federal government is making its moves into areas where, to its own satisfaction at least, it is able to demonstrate unfilled needs for health care or health care planning. If we are alert to our responsibilities for filling all of the apparent vacuums in communitywide health programs, we can eliminate areas which may seem to demand government involvement."

"Leadership will be provided," Dr. Rouse said, "in these areas of community planning and the provision of community health services for all people. The only undefined factor is the source of that leadership. If it is not the physicians of the community, it will be government in one of its many forms."

President Rouse listed some of the many problems now facing the medical profession, asserting however that "this is a time not for despair, but for a clear recognition of crises that are approaching; a time not for anger and frustration, but for unswerving determination to face our problems and solve them; a time not for philosophy alone, but for action to make our philosophy a reality."

In his report to the House Thursday, President Rouse elaborated on that theme and listed what he considers to be some of the solutions to the problems facing medicine. Among the items he included were more unity within the medical profession; greater interprofessional harmony with all other elements of health care; better communications between physicians and their societies at every level, and between physicians and the public; increased participation by physicians in the deliberations and programs of the medical associations; more activity by physicians in the political and civic affairs of their communities; and the development of citizen interest in matters of over-all health.

"As we have done in the past," the President told the House, "we shall gladly respond to requests from government or from any other source for advice on health matters. . . . But, as in the past, we shall insist that we be approached in good faith, with the assurance that our freedom of judgment and freedom of action will be preserved."

"Our future," he concluded, "will not be determined by those who oppose us, but by our own willingness to accept the responsibilities which are naturally ours."

Actions of the House

Of the 10 reports from councils considered by the House, all were adopted in their presented form except two from the Council on Medical Service which were amended and adopted. Of the 18 Board of Trustees reports, 13 were adopted as presented; two were amended and adopted; two were accepted for information; and one was referred back to the Board along with state resolutions on the same subject.

After many hours of reference committee hearings and additional debate on the floor of the House, 27 of the 123 state resolutions were adopted; another 25 were amended and adopted; 27 were referred to the Board or to one or more councils; 22 were combined with one or more others into substitute resolutions; eight were replaced by substitute resolutions; and 14 were not adopted.

The will of the House was expressed on a great variety of subjects.

Therapeutic Abortion

One subject that has generated interest not only in the profession but among legislatures and the public is therapeutic abortion.

The House updated the Association's 1871 policy on the subject which, according to the reference committee report which was adopted, was not only antiquated but lacked even the rudiments of adequate safeguards to prevent abuse. The updated policy, the House agreed, is in keeping with modern scientific knowledge, contains necessary safeguards and permits the physician to exercise his personal conscience and medical judgment in the best interest of his patient, over-riding objectives in any medical decision.

The following was established as policy of the American Medical Association:

" . . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances, the American Medical Association is

opposed to induced abortion except when:

“(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

“(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

“(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

“(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

“(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

“It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion.”

Health Care Cost

“Today . . . the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care.” That is a statement from the Board of Trustees report adopted by the House with the provision that it be widely disseminated for study and evaluation as to its applicability in local areas.

“Indeed,” the report continued, “if the price of health care continues to outrun slower increases in consumers’ income, the problem of medical indigency will assume alarming proportions.”

Basic problems in the over-all design of the nation’s health care system, as shown in the adopted report, include inadequate numbers of new

physicians and shortages of other individuals trained to function as part of the health care team; the present organization and management of the nation’s hospitals, with respect to their “privilege of automatically translating all higher costs into higher prices” which “must now be questioned;” diagnostic and therapeutic care outside of a hospital; and legislation in the health field.

A number of actions were taken to outline possible solutions to the problems of higher health care costs. One important one was the adoption of a progress report on strengthening and improving voluntary health insurance programs, submitted by the Council on Medical Service. The House accepted the Council’s statements that it would “continue to study the scope and patterns of benefits, public demands for coverage, the performance of health insurance and prepayment programs and accumulation of data for future use;” and that the Council would “proceed to develop guiding principles for health insurance and prepayment programs.”

As further efforts in this direction, the House referred to the Board and to the Council on Medical Service a resolution that the AMA “consult with insurers in an effort to change their policy of insurance coverage so that payment can be made for diagnostic procedures and minor surgery performed in the physicians’ office and/or in the hospital outpatient department;” adopted a resolution that the Association petition congress to remove the restriction on first-dollar deduction from income tax laws for health care expenditures; and adopted the over-all policy that “physicians . . . continue to do everything possible to help the public conserve its health care dollars.”

Government Health Programs

As might be expected, a great many reports and resolutions dealt directly or indirectly with the Association’s relationships with government and with the multitude of gov-

ernment programs existing or proposed in the health field.

The House re-affirmed Association policy that “The medical profession has long and consistently held to two basic positions concerning personal health care and its financing: that no one should go without needed care because of inability to pay, and that responsibility for payment rests first on the individual himself and then, to the extent that he is unable to pay, on his family, the community, the county, the state, and, to the extent that lesser levels of government are unable to finance the care, the federal government.”

Regarding the Title XIX program, the House made it policy that “the medical profession should now take a firm stand in support of the Title XIX approach in improving the health and the delivery of health care services to the needy of the nation.”

Recommendations adopted by the House are that the medical profession take a strong stand in support of implementation of Title XIX “while still seeking such changes in the federal legislation and/or regulations as will improve this program; that it urge organized medicine to take a leading role in formulating and directing Title XIX programs at the state and local level . . . and that it incorporate in such planning the use of existing voluntary mechanisms and private insurance carriers, wherever feasible, utilizing the usual and customary fee principle, thus bringing within the mainstream of present medical care systems the provision of quality health care for all Americans.”

Appalachian regional health programs were the subject of a number of resolutions and the House adopted the following guidelines for setting up any such programs: (1) demonstrated need for the proposed project; (2) local control; (3) participation of a significant proportion of local physicians in planning and development of the project; (4) the operation of any regional, area or county health service facility shall

not infringe upon the private practice of medicine; (5) all health services, whether preventive, prophylactic or therapeutic, shall be rendered at a cost to the patient commensurate with the social and economic status of the patient; (6) there shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities; (7) these health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

More generally, in connection with any and all government medical care programs, guidelines were adopted by the House:

"The medical profession in any community is best represented by the local medical society and its officers. They should be consulted initially, and during the process of planning of any and all projects for the care of the sick and the preservation of health."

In proposing any new facility, "It shall be first determined that existing facilities are so inadequate that only a completely new facility will provide a solution.

"The responsibility for the health needs of a community basically resides at the community level, and all the local resources . . . shall be examined before the community accepts government monies.

"If it is deemed advisable to operate a government-financed facility in a community, it shall in no way be binding upon a physician to refer his patients there; to coerce a physician to service the facility; and this facility must in no way infringe upon the private practice of medicine.

"These projects should not be developed or operated in such a manner as to establish a precedent that could lead to a governmental controlled medical care system in this country."

Physician Control Over Collection and Disbursement of Professional Fees

In adopting a report of the Council on Medical Service regarding collection and disbursement of professional fees, the House reaffirmed past action and provided clear, consistent policy statements reflected in these thoughts which are elaborated in the full report:

1. It is proper for the physician to establish the fee he charges to any patient for professional service rendered, with the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

2. It is proper for third party agencies to make payment of professional medical fees for patients.

3. It is proper for a physician to work with other physicians in a team approach to the provision of medical service, recognizing that each is entitled to compensation according to the value of his services and that charges attributable to each physician's service shall be made clear to the patient.

4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for him unless it is with the consent of the physician and of the medical staff.

6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit, disburse as they may agree.

7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

8. The physician is the sole arbiter as to ways he may dispose of his

professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

Millis Commission and Commission on Research

Because the contents of the Millis Commission report (Citizens Commission on Graduate Medical Education) relate so specifically to the roles of the Councils on Medical Education and Medical Service, the two councils have assumed responsibility for assembling critiques and information. At a later date, they will bring to the Board, and subsequently to the House, recommendations for implementations of parts or the whole of the report. The House urged all interested members of the Association or groups to submit comments, suggestions or recommendations for consideration by the two councils.

With respect to the Commission on Research, the Board has established a Committee on Research to review reports on the subject from the Councils on Medical Education and Medical Service; refer portions of the report to other councils and committees; and confer with those groups in addition to receiving their reports.

Again, the House urged any interested individuals and groups to forward comments and suggestions to the Executive Vice President for transmittal to the committee.

Medicine and Osteopathy

The House adopted the following recommendations of the Board regarding the medical profession's relationships with osteopathy:

1. Authorize the Board of Trustees to begin promptly negotiations directed toward beginning official change of schools of osteopathy to schools of medicine. (It is understood that from the American Medical Association funds will be required to conduct these negotiations, and assistance in identifying and securing additional funds from other sources to support efforts toward

changing the schools.)

2. Authorize the Council on Medical Education to undertake negotiations to establish means by which selected students with proven satisfactory scholasticability in schools of osteopathy may be considered by schools of medicine for transfer into medical school classes.

The primary issue in the relationship of medicine and osteopathy, as recognized by the House, seems to be not that of cultism as opposed to science. Rather the issue appears to be one level of medical education and practice as opposed to another and lower level of education and practice. The extensive and growing licensure of osteopathic physicians for the unrestricted practice of medicine and the nature of osteopathic education strongly indicate that time alone will resolve shortly the problem of cultism in relation to osteopathy.

Medical Manpower

The House accepted for information a report from the Board which pointed out that "The production of well-qualified physicians in adequate numbers is necessary to meet effectively both social and economic demands for health care." It reviewed some of the activities of the Committee on Health Manpower and concluded that "The AMA should continue to study the effect of new roles for health personnel and new interrelationships and interdependencies between health professionals, as well as the impact of innovative concepts on the organizational structure evolving in the general system of health care delivery. . . .

"In any event, our resolve should always be as it is now: to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated and highly skilled physicians."

The House also referred to the Board, for consideration by the committee, a resolution that "deliberations include strong emphasis on sound ways of accelerating medical

education in all its phases, including post-MD and graduate education, and of increasing the supply of physicians in all categories."

In addition, the House adopted reports calling for revision of the Essentials of Approved Residencies in radiology, obstetrics and gynecology; adopted a resolution calling for the promotion of better practices in inhalation therapy; and adopted a resolution that the AMA reaffirm its support of all forms of nursing education; that hospitals which conduct diploma schools of nursing be commended; that such hospitals be urged to continue their schools and increase enrollment; and that the AMA take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

Committee on Planning and Development

At the June, 1966, convention of the House, the Board announced the appointment of a committee to study planning and development techniques within the Association. The report of the committee was received and the Board submitted its final report to the House at this convention.

The Board voted to (1) establish a permanent Committee on Planning and Development and (2) select seven active members of the AMA as members. The following charges were established for the committee:

1. Study and make recommendations concerning the long-range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them.
2. Serve as a focal point for the planning activities of the Association and stimulate and coordinate planning activities throughout the organization.
3. Study, or cause to be studied, medicine and the environment in

which the Association must function and transmit the conclusions of these studies to the Board.

In the report adopted by the House, the Board earnestly solicited nominations to the committee from delegates, constituent associations, component societies and other interested groups and individuals.

Two resolutions on the subject were referred to the Board.

It is noteworthy that in his report to the House, President Rouse stated that "We now have an established Committee on Planning and Development at the AMA level. I hope that every county and state association will likewise make use of a comparable committee, to plan wisely and develop properly the policies and programs needed in the decades ahead — far beyond just the next year."

Members' Disability Insurance Program

The House adopted the report of the reference committee on this subject, and referred to the Board a number of resolutions pertaining to it.

The committee's report, as adopted, recommended that the House authorize the Board to make every effort to continue the AMA Members Group Disability Insurance Program with the same premium-benefit structure. It also recommended the following guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program:

1. The contract should provide ample assurance that disability claimants will be treated equitably and justly.
2. The carrier should guarantee benefits and premiums for a period of at least five years in order to assure the stability of the program.
3. Promotional literature should be approved in advance by the Board or its designee. All measures within the bounds of dignity and ethics should be utilized to promote the

program.

4. A continuous ongoing review of the entire program should be maintained. The insureds and other members should be made aware that such a review may reveal in the future the necessity for a revision of the program at the end of the five-year period.

5. Information regarding the operation of the program, its financial aspects and the processing of claims should be available to the Board for review at any time.

6. An AMA Disability Insurance Review Committee should be continued and should provide a mechanism for claims review.

Political Action

Several resolutions were offered to the House questioning whether the administration of government programs is truly carrying out the intent of Congress in its passage of laws. They were combined by the House into one resolution stating "That if legislation is introduced to investigate the activities of the Department of HEW and its executive personnel who are concerned with health matters to determine if the intent of Congress is being carried out, the American Medical Association will provide to such an investigation any information that its Board and councils may secure in these matters."

The resolution also pointed out that since the most effective method to preserve the private practice of medicine is to elect proper officials at all levels of government, "the American Medical Association urges that physicians, as individuals, redouble their efforts in political activities."

It was also resolved that the Association "continue and expand its efforts to inform our membership of its activities to represent them, particularly before the Congress and the federal agencies."

The House also adopted a resolution "That medical societies be urged to investigate, document and

report to the Law Division . . . all violations of Public Law 89-97 by officers or employees of the federal government" and that "a status report be provided to this House at the 1967 Clinical Convention."

The House also reaffirmed the Association's opposition to S. 260 (the Hart Bill) and its support of direct billing under Part B of medicare on the basis of a physician's itemized statement of charges.

The House supported AMPAC and the state PAC organizations by adopting a resolution recognizing "that leadership at all levels of medicine should make individual commitment to state PAC-AMPAC membership and local PAC programs, wherever this is legally possible."

Generic Prescribing

A resolution combining several state resolutions was adopted by the House, asserting "that the AMA again reaffirm its policy that physicians should be free to use either the generic or the brand names in prescribing drugs for their patients; and encourage physicians to supplement medical judgments with cost considerations in making this choice."

Other Actions

During the convention, the House welcomed 15 physicians who have served in the Volunteer Physicians for Vietnam program; conducted a memorial service for 27 members of the House and/or officers of the Association who had died since the 1965 Annual Convention; heard a report on AMPAC from Blair J. Henningsgaard, M.D., chairman of the AMPAC board; heard a report on AMA-ERF from Immediate Past President James Z. Appel, M.D., President of AMA-ERF; permitted a representative from the Oregon Woman's Auxiliary to introduce to the House the "Doctor's Wife," a new rose developed by the Oregon auxiliary; and heard a talk by David Kindig, president of the Student American Medical Association.

Adopted many other resolutions, including these:

Amending the bylaws so that recipients of the Distinguished Service Award and the Citation of a Layman for Distinguished Service will be nominated at the Clinical Convention and the presentations will be made at the next Annual Convention.

Confirming that there is nothing in the military officers' oath that conflicts in any way with the ethics of the medical profession.

Noting that a double standard of policy often exists between so-called "hospital-based specialists" and other types of practitioners with respect to hospital staff appointments and endorsing "the principle of a single standard with respect to staff appointments among all physicians having equivalent credentials in all hospital departments and services as a means of assuring maximum freedom of choice of physicians by patients, and of consultants by staff members."

Requesting the JCAH to "encourage . . . the acceptance, wherever possible, of physicians elected or appointed by the medical staff to the Board of Trustees with full voting rights as the most effective form of liaison between the medical staff and hospital governing authorities."

Opposing the establishment of a racial quota system for hospitals.

Encouraging farm equipment manufacturers to establish standards for basic overturn protective frames and crush-resistant cabs.

Reaffirming the Association's policy regarding tobacco and health and promising vigorous continuation of its measures for corrective action.

Urging that disposable hypodermic syringes be thrown away in such a way as to prevent their possible re-use.

Encouraging state associations to inform state legislators of the need to re-examine existing "battered child" laws so child abuse is to be reported by physicians as well as medically oriented social services.

Supporting continued research and

control measures for venereal disease. Reaffirming the Association's opposition to requirements for certification and re-certification.

Stating the Association's continuing concern for the prevention of death and injury from burns by "stepping up its education campaign to make the public more aware of the dangers inherent in flammable fabrics and other related flammable

materials" and resolving that "the AMA cooperate with other voluntary associations in the furtherance of this program."

Finally, the House welcomed as its guests at the opening session the winners of the AMA's top awards at the 18th International Science Fair, held in San Francisco. They were Susan T. Bertrand, New Albany, Ind., whose exhibit was "Electro-

phoretic Analysis of Blood Serum;" and Stephen R. Igo, Winterset, Iowa, with an exhibit showing the design, construction and operation of a small, synchronous intrathoracic auxiliary ventricle. Both winning exhibits were on display during the convention. ◀

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Association

Medical Panorama

Hoosier Population Trends

A. W. CAVINS, M.D.
Terre Haute

Apparently, the "population explosion" has involved, in Indiana, chiefly those of elementary school age, 6 to 13 years. Between 1950 and 1960, this segment increased 50%. Figures on this subject, published in *The Indiana State Board of Health Bulletin*, December, 1966, are most enlightening, and in some respects surprising. The essential information is given in the following extract:

In summary, Indiana has not grown in the sixties as it did in the previous decade. Two essential factors in this slowing of growth have been decline in births and net out-migration. It is, at present, thought likely that both of these factors will have a reversal of direction in the near future.

Groups whose rapid growth in the near future may be expected to make added demands on the state's economy are high school and college age youth as well as young adults. On the other hand, on a statewide basis the peak is now being reached in the number of elementary school children. Persons over 65 are on the increase, but not in proportion to the entire population. What new demands these

older people may place on the economy will be because of expanded programs and not because of the group's increase in size.

Of great interest to the Hoosier medical profession, and to its medical educators, is the net out-migration which has averaged 20,000 to 25,000 persons who have left the state each year since 1960. Considering Indiana's economic health, "there appears to be no satisfactory explanation of this present trend." A certain percentage of this out-migration represents a "brain-drain" in the form of medical graduates trained here, but settled finally elsewhere. The need for adequate high-grade residencies in Indiana is not only acute, but urgent; and simply increasing the number of medical graduates will not stop their out-migration. Attractive opportunities for immediate postgraduate education, however, should be of the greatest help. ◀

FDA, AMA, PMA Calling All Physicians!

I have already begun to explore ways in which the Food and Drug Administration can keep the medical community — and I would include industry here as an equal partner — adequately informed of our deliberations and our actions. The FDA is late in this effort. Late, also, is the larger medical community, whose components — hospitals, clinics, dispensaries, infirmaries, doctor's offices, and medical schools — are still not in continuous, effective contact.

This is not easy for me to say because as a physician, I would hope that physicians would lead the way in this important venture. They and their patients would benefit most from an orderly information system within the medical community. — James L. Goddard, M.D., to American Society of Internal Medicine, New York, April 15, 1966.

* * * *

Drivers under 25 years of age continue to compile the worst traffic records of any age group, according to a report from The Travelers Insurance Companies. Young drivers were involved in almost 32% of highway deaths last year.

Open Letter to All Indiana Physicians:

Testing of School Children for Tuberculosis

Pursuant to Chapter 28, Acts 1967, Indiana General Assembly, the school officials of each school corporation in the state shall, upon enrollment of any child for the first time in any school corporation, require the parents, or guardian to furnish written evidence that such child has been tested for tuberculosis. Such written evidence shall show the name, residence, age, sex of such child, the kind of test used, the result of such test, and shall be signed by a person authorized to practice medicine without limitation in Indiana.

This Act provides that the State Board of Health may prescribe the kind and nature of such test as well as the form of such report by the physician. Therefore, for the purpose of this Act any tuberculin test usually performed by the physician would be in compliance with the Act. However, it is recommended that all positive reactors be confirmed by an intradermal Mantoux using intermediate strength O.T. or PPD-s, if the intradermal Mantoux was not initially used. Under no circumstance will the patch test be deemed to be in compliance with this Act.

The various school corporations will be sent a format of the physician's reporting form for printing

and subsequent distribution to local physicians prior to the opening of school this fall.

A copy of this short Act is reproduced to permit detailed review and perhaps answer some questions that may arise. Your attention is invited to Section 2 of the Act wherein no test is required if the parent in good faith, relies on spiritual means or prayer for healing.

CHAPTER 28, Acts 1967
Approved March 1, 1967

Tuberculosis Skin Testing School Children

AN ACT concerning the testing of school children for tuberculosis.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. The school officials of each school corporation in the State of Indiana shall, upon enrollment of any child for the first time in any school of the school corporation, require the parents, guardian, or person having the control and custody of such child, to furnish written evidence that such child has been tested for tuberculosis. Such written evidence shall be on such form as may be prescribed by the State Board of Health of Indiana, and shall show the

residence, age, and sex of such child, the kind of test used, the result of such test, and shall be signed by a person authorized to practice medicine without limitation in Indiana.

SECTION 2. The State Board of Health may prescribe by regulation the kind and nature of such test, and the form of the said report, except that in cases where the parent, guardian, or person having custody and control of such child in good faith relies upon spiritual means or prayer for healing, no test shall be required.

If any parent, guardian, or person having custody and control of such child is financially unable to pay for such testing and report, the school corporation enrolling such child shall pay for the same.

SECTION 3. Not later than sixty (60) days after the enrollment of such child, the school officials of the several school corporations of the State shall file a written report with the Indiana State Board of Health, Division of Communicable Diseases, in a manner as may be prescribed by the State Board of Health stating the identity of such children as were shown to have tuberculosis or be tuberculin reactors. ◀

A. C. Offutt, M.D., Secretary,
Indiana State Board of Health



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odium
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

Changes in Blue Shield Payment Patterns

(One of a series prepared by Blue Shield)

Medical practice has undergone many changes since 1949, and expanding Blue Shield benefit programs continue to keep up with these changes.

Our sales efforts continue to place emphasis on selling the local county programs or usual and customary programs for surgery and anesthesia,

in-hospital medical protection and diagnostic and pathology endorsements.

The table below graphically indicates changes in Blue Shield payment patterns, analyzed in terms of medical classifications. For example, anesthesia and diagnostic benefits were not available in 1949. In 1966,

anesthesia payments totaled \$2,076,517, and diagnostic payments reached \$2,813,868. Payments for in-hospital medical services increased from \$8,411 in 1949 to \$4,095,108 in 1966. Blue Shield Medicare Supplement payments for the first six months of the program were \$423,164.

AMOUNT PAID

MEDICAL CLASSIFICATION	1949	1966
SURGICAL:		
T & A	\$144,955	\$ 683,685
Eye, Ear, Nose & Throat	72,388	1,606,623
Appendectomy	205,840	404,668
Hernia	42,690	832,489
Abdominal	91,910	1,483,110
Proctology & Urology	109,518	1,680,233
Orthopedics	114,395	2,311,051
Radiation Therapy	9,786	262,019
All Other Surgical	110,903	3,655,923
Total Surgical	\$902,386	\$12,919,806
MEDICAL:	\$ 8,411	\$ 4,095,108
MATERNITY:		
Deliveries	\$259,764	\$ 1,766,139
Gynecology	261,854	1,773,367
Total Maternity	\$521,618	\$ 3,539,516
ANESTHESIA:	*	\$ 2,076,517
DIAGNOSTIC:	*	\$ 2,813,868
MEDICARE SUPPLEMENT:	—	\$ 423,164
GRAND TOTAL	\$1,432,415	\$25,867,982

* These benefits were not available in 1949.

W. C. Huddlestone
Communications Division

The Cancer You View

DISCUSSION

This cervix, showing only a small erosion, is the site of preinvasive squamous cell carcinoma (carcinoma-in-situ). The average age for the diagnosis of this lesion is 38 years. Visual examination of the cervix with a water or saline lubricated speculum is a basic part of the routine physical examination of this patient. "Pap" smears, from the cervix and the endocervical canal, and the posterior fornix must be obtained. When there is a specific lesion of the cervix, a punch biopsy should also be performed. Visualization of specific areas for biopsy may be aided by applying Schiller's Solution to the cervix. Normal areas will turn reddish-brown by reacting with the iodine of the solution. Unstained areas should be scraped for smears or biopsied.

If the cytologic report is Class I (negative), the smear should be repeated in one year (or every six months after the age of 40). If the report is Class II (hyperplastic epithelial cells) the smear examination should generally be repeated in three months, after appropriate therapy to the cervix for any cervicitis which may be present. A Class III report indicates the presence of atypical epithelial cells and should be regarded as suspicious. Smears should be repeated along with a Schiller staining of the cervix.

When punch biopsies are performed the reports may be negative (or cervicitis) only; dysplasia (an atypical metaplasia which may be premalignant) or carcinoma, either in-situ or invasive. A negative biopsy with persisting Class III smears will eventually need conization biopsy. Punch biopsies with diagnoses of dysplasia and/or in-situ carcinoma require conization biopsy for definitive diagnosis and therapeutic considerations. If invasive carcinoma is proven, appropriate therapy may be

instituted without further biopsy.

Class IV reports indicate the presence of cells with malignant characteristics and ordinarily require conization biopsy in the absence of areas clinically indicating invasive carcinoma.

The treatment of benign cervicitis will fall into two categories: antibacterial creams or ointments, and cautery, either electrocautery or chemical (silver nitrate). Less commonly used methods include carbon dioxide ice cautery, douches and enzyme ointments. Cautery of any kind should not be used prior to receiving a negative or Class II report from the "Pap" smear. Appropriate treatment is usually rewarded by success. Cervicitis and erosions which persist are associated with a definite increase in the incidence of cervical malignancies. For this reason, active therapy of cervicitis and regular cytological examinations are necessities.

Treatment of cancer of the cervix must be individualized according to its extent. Preinvasive cancer of the cervix (International Stage 0) should be treated with either a simple hysterectomy and excision of a wide cuff of vaginal mucosa at the cervix, or (if the patient desires to retain her child-bearing ability or is not medically a candidate for hysterectomy) by a wide and deep conization. These patients must be followed carefully (every three months) with "Pap" smears for evidence of residual or recurrent changes. Patients treated by hysterectomy should also be followed periodically with "Pap" smears of the vaginal vault since there is a one percent incidence of dysplastic or malignant change at the apex of the vault. Irradiation therapy has no place in the treatment of preinvasive cancer of the cervix. The cure rate for Stage 0 carcinoma of the cervix is virtually 100% if properly diagnosed and treated.

Invasive carcinoma confined to the

cervix (Stage I), may be successfully treated by either irradiation therapy or radical surgery (Wertheim-type hysterectomy). The decision as to which will be employed may depend on the availability of experienced radiation therapists or surgeons in the community. Five-year survival rates of approximately 75% may be noted with either modality of treatment.

Stage II cancers are those limited to the cervix, parametria, upper one-third of the vagina or endometrial cavity. Although these are amenable to the same treatments, irradiation is more often used. The five-year survival rate is approximately 50%.

Stage III carcinomas have extended to the lateral wall of the pelvis or the lower one-third of the vagina. The five-year survival is approximately 30%. These patients generally are irradiated. Some are treated by an ultra-radical surgical approach, such as pelvic exenteration.

Stage IV lesions are those which have extended into the bladder, rectum, or vulva or which have metastasized distantly. These patients have a very poor prognosis (seven percent five-year survival) and are usually only palliated by extensive surgery or irradiation. Chemotherapy is very disappointing. Regional perfusion of the pelvis has shown some success but is only palliative.

It is obvious from these figures that the best time to discover a carcinoma of the cervix is when it has just developed, i.e., in the preinvasive stage. The only way these clinically invisible cancers can be detected early enough to provide an acceptable cure-rate is to perform routine periodic "Pap" smears of the cervix.

Because of the high degree of accuracy of Papanicolaou smears, the general rule should be that all women examined should have "Pap" smears beginning with the onset of sexual activity or age 21, whichever occurs first. These should then be repeated yearly thereafter and at six-month intervals after the age of 40. ◀

WANTED: Locations Physicians

GENERAL PRACTICE

Harold Z. Johnson, 7101 Woodrow, Austin, Texas 78757

Michael F. Deery, Box C, Belcourt, North Dakota 58316—available 4/1/68

Richard P. Rudnicki, 3008 Oak St., Mattoon, Ill. 61938—with obstetrics

SPECIALISTS

Cesar and Hilda Perez, Dixon State School, 2600 Brenton Ave., Dixon, Ill.—*Anesthesiology*

Ravinder N. Agarwal, 29 Glendhu, Buffalo, New York 14210—*Ear, Nose and Throat*

Arnoldo Fiedotin, 1581 Lee Terrace Dr., Wickliffe, Ohio 44092—*only interested in working in a Cardiac Laboratory*

Paul E. Brose, 1300 W. Michigan St., Indianapolis, Ind. 46202—*Internal Medicine*

Richard A. Kellar, 45 Wheeler, Fort Leonard Wood, Mo. 65473—*Ophthalmology, available May, 1968*

Thomas J. Setter, 8276 Fisher, Warren, Mich. 48089—*Orthopedics—available January, 1968*

Edwin E. Ziegler, 505 Ohio Ave., Phillipsburg, New Jersey 08865—*Pathology*

Marvin E. Deck, Jr., 1457 Elliott St., S. E., Grand Rapids, Mich. 49507—*Surgery—available 7/68*

James D. King, 1526 N. Edgemont St., Los Angeles, Calif. 90027—*Surgery*

John H. Hughes, 7401 E. 49th St., Lawrence, Ind. 46226—*Surgery—available 7/68*

Joseph P. Dineen, 412 Mix Ave., Hamden, Conn. 06514—*General and Thoracic Surgery*

John P. Coughlin, Capt., M. C., 5674-2 Carter St., Fort Hood, Texas 76544—*Urology—available 7/68*

Bruce F. Knoll, Box 195, Henry Ford Hospital, Detroit, Mich. 48202—*Urology—available 7/68*

LeRoy M. Henrich, Jr., Huntley Road, Norwich, Vt. 05055—*Urology—available 7/68*

Walter C. Babcock, 2000 Santa Clara Ave., Alameda, Calif.—*Administrative, Teaching, School Health*

Glenn D. Blaisdell, 112 Johnson, Marshall, Texas 75670—*Student Health*

OPENINGS FOR GENERAL PRACTICE IN INDIANA

County Town

Adams—BERNE—population 2,300. Located in the northeastern part of Indiana. Three general practitioners in the area. A 72-bed county hospital located in Decatur which is approximately 20 miles distant. Contact Martin Graber, M.D., Secretary, Adams County Medical Society, 265 W. Water St., Berne.

DECATUR—population 8,327. County seat town with a 72-bed county hospital. Need for general practitioner. Contact Martin Graber, M.D., 265 W. Water St., Berne, 46711.

Blackford—HARTFORD CITY—population 8,500. Need for two general practitioners. County seat town with a 46-bed hospital. Survey being made to determine needs and size of a new hospital. Contact David J. Bennett, Manager, Chamber of Commerce, Box 286, Hartford City 47348.

Carroll—FLORA—population 1,727 with a projected census in 1970 of 2,900. Population retail trading area 12,000. Located 65 miles from Indianapolis, 20 miles from Frankfort and Kokomo and 25 miles from Lafayette and Logansport where hospital facilities are available. One practicing physician in community. Office and equipment available. Community Club Board working on a proposed modern medical center for two or three physicians and a modern community nursing home. Financial aid in community is available. Contact R. C. Julius, P. O. Box 67, Flora 46929. Telephone (office) 967-4232 and (home) 967-4368.

Cass—LOGANSPOUT—population 21,700. Two hospitals. Opening for general practitioner. Primary source of income—industry, railroads and farming. Contact Paul H. Wilson, M.D., 422 North St., Logansport 46947.

Clinton—COLFAX—population 800. Located close to Lafayette and Frankfort where hospital facilities are available. Community without the services of a physician. Large surrounding area. Rich farming area. Contact Mr. John Gilmore, P. O. Box 187, Colfax 46035.

MULBERRY—population 1,100 with a surrounding population of 2,000. Located 10 miles from Lafayette, home of Purdue University, and two excellent open staff hospitals. Ten miles from Frankfort, county seat, where the 83-bed county

hospital is located. Mulberry is located in a rich farming area. No physician in the community. Contact Eldon Skiles, Farmer's Bank or Mrs. Bert V. Livelsberger, 517 W. Perrin St., Mulberry 46058.

Decatur—GREENSBURG—population 10,000. Industrial and farming community located between Indianapolis and Cincinnati, Ohio. Eighty-four-bed county hospital with new facilities. Need for four general practitioners. Contact Bernard C. Harvey, Administrator, Decatur County Hospital, Greensburg 47240.

Delaware—MUNCIE—population 70,000. Openings for doctors specializing in internal medicine and pediatrics. 12,000 student Ball State University located here with its cultural benefits. Ball Memorial Hospital has 465 beds and 150 additional bed addition under construction. Contact Mr. Pence, Manager, Muncie Clinic, 420 West Washington St., Muncie 47305.

Fayette—CONNERSVILLE—population over 20,000. Is equidistant (60 miles) from Indianapolis, Cincinnati and Dayton, Ohio. New recreation lake under construction—one of the largest man-made lakes in the country. All manufacturing concerns are enlarging and working full time. Eight active general practitioners for this rapidly expanding city. New 109-bed hospital run by a non-profit association. Contact J. L. Steinem, M.D., Secretary, Fayette-Franklin County Medical Society, 818 Grand Ave., Connerville 47331.

Floyd—NEW ALBANY—population 38,218. Located in southern Indiana on the Ohio River. There are opportunities for general practitioners, either to come into practice alone or to associate with any of two or three others. Memorial Hospital (210 beds) located there. Contact Daniel H. Cannon, M.D., Secretary, Floyd County Medical Society, 1201 E. Spring St., New Albany 47150.

Fountain—HILLSBORO—population 600. Located 14 miles from the 83-bed Montgomery County Culver Union Hospital in Crawfordsville, home of Wabash College. No physician in the community. Office available which will be rent free for six months. Contact Mr. R. M. Osborn of the Booster Club, Hillsboro 47949.

VEEDERSBURG—population 2,500 with a large surrounding area. One physician in the town. Located on new Interstate

I-74 a direct route to Crawfordsville and Danville, Illinois where hospital facilities are available. Also small hospital at Williamsport, 16 miles away. Primary sources of income are from farming, Steel Castings Foundry and brick factory. Olin-Mathiewson plant nine miles west. Contact Mr. Vern French, 117 E. Second St., Veedersburg 47987.

Fulton—LEITERS FORD—Merchants Association interested in obtaining a physician for the community, located 13 miles from Rochester where there is a 61-bed county hospital. Contact Mr. Ernest L. Hiatt, Leiters Ford 46945. Telephone 832-4460.

Gibson—OWENSVILLE—population 1,100 with a large surrounding territory, mainly farming community. Twenty-five miles from Evansville where three hospitals are available. Fifteen miles from Princeton where a new 80-bed hospital is located. No physician in the community. Contact Marion E. Warpenburg, D.D.S., Owensville 47565.

Grant—SWEETSER—population 1,000. Located close to Marion where there is a 244-bed general hospital. No physician in the town. Contact Mr. R. H. Allen, Box 196, Sweetzer 46987.

UPLAND—population between 2,000 to 2,500. Principal economies are industry, agriculture and education. Home of Taylor University which has an enrollment of 1,250 students. Located 14 miles from Marion and eight miles from Hartford where hospitals are available. One physician in the community who has a limited practice. New industries locating in the community. Citizens of the community as well as officials at Taylor University willing to cooperate in helping a physician establish a practice. Contact Mr. Hugh Freese, P. O. 248, Upland 46989. Telephone 998-2125.

Greene—WORTHINGTON—population 1,700. Nearest hospital (73 beds) is located at Linton which is 13 miles distant. New gypsum plant being started. Office available. Contact Mr. G. E. Conway, 2 Washington St., Worthington 47471.

Harrison—PALMYRA—population 350, located in southern Indiana. Principal economies are labor and agriculture. Hospitals located at Corydon 15 miles away and at New Albany and Salem 18 miles distant. Contact Mr. Charles E. Fessel, R. R. # 1, Box 240, New Salisbury 47161.

Hamilton—NOBLESVILLE—population 7,500. Located 25 miles north of Indianapolis. County seat town with an 86-bed new county hospital. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville 46060. Telephone 733-0284.

Hendricks—DANVILLE—population 4,200. County seat town with a 70-bed hospital. Located 18 miles from Indianapolis on U. S. 36. Growing community. Contact Billie Dee Falls, Chamber of Commerce, 64 S. Jefferson St., Danville 46122.

Henry—MT. SUMMIT—population 500. Five miles from New Castle where a 194-bed county hospital is located. Mixed farming and industrial area. Several small communities within a radius of ten miles without a physician. Contact Mr. Thomas Bowers, Box 136 or Mr. R. L. Beavers, Mt. Summit 47361.

Howard—GREENTOWN—population 1,751. Located nine miles from Kokomo where two hospitals are available. Most any kind of office required is available. Community needs and can support another physician. Contact Mr. Richard Zirkle, 508 E. Main St., Greentown 46936.

KOKOMO—population 47,197. Two hospitals. Need for general practitioners. Contact Jack Higgins, M.D., Secretary, Howard County Medical Society, 400 S. Berkley Rd., Kokomo 46901.

Huntington—HUNTINGTON—population 17,000 with a new 100-bed hospital. Huntington is in the center of a new recreational area with three large reservoirs. Office space is immediately available in a new professional building. At the present time there are eight general practitioners. Contact Paul E. Doermann, M.D., 1775 N. Jefferson, Huntington 46750. Telephone (219) 356-4520.

HUNTINGTON—see above information. Office of the late Dr. F. B. Mitman who practiced in Huntington for 40 years available. Contact Donald J. Klepper, 35 W. Market Street, Huntington 46750.

Jackson—BROWNSTOWN—population 2,500. Seven small towns within a radius of ten miles and only three doctors in Brownstown to take care of this area. Ten miles from Seymour where a 100-bed county hospital is located which is being expanded at this time. Contact Mrs. Keith Smallwood, Chamber of Commerce, Brownstown 47220.

MEDORA—population 900. Located in the south central part of Indiana. The principal economy is small industry and agriculture. Large surrounding rural area. No physician in the town. Office and house available. Located 20 miles from Bedford, Seymour and Salem where hospitals are available. Contact Mr. Bernard Toon, P. O. Box 337, and Mr. Ed Kasting, Medora 47260.

Jasper—REMINGTON—population 1,110. One physician in the town. Nearest hospitals are located at Brook and Rensselaer. Located in the northwestern part of Indiana. Contact Mrs. Nettie R. Lambert, R. R. #1, Remington 47977.

Jay—REDKEY—located in the northeastern part of Indiana with an estimated population of 1,850 and an estimated 8,000 people in a five-mile radius. Hospital facilities located at Portland, 11 miles; Muncie, 19 miles and Hartford City, 15 miles. Construction of a medical building being started which will be available for lease with an option to purchase. Contact Rev. Charles Fields, 122 W. Main St. and Mr. Richard L. Gast, Box 324, Redkey 47373.

Johnson—MT. PLEASANT & SMITH VALLEY COMMUNITIES—located in the northern part of Johnson County—eight miles from Franklin where a 128-bed county hospital is located. New office available or will build to suit tenant. Northern Johnson County is one of the fastest growing areas in the state. Franklin is 18 miles from Indianapolis. Contact Mr. Robert McDonald, R. R. # 2, Box 194, Greenwood 46142.

Lake—GARY—population 178,320. General practitioners, allergist, internist, orthopedic surgeon, ophthalmologist, pediatrician and psychiatrist to join 24-man clinic. New clinic building with complete x-ray and laboratory facilities. Two excellent open staff hospitals. Contact R. Lyle Fosler, The Gary Clinic, 6111 Harrison St., Gary 46408.

Lawrence—MITCHELL—population 4,000—located in the south central part of Indiana. The principal economies are industry and farming. Ten miles from Bedford—a 100-bed county hospital available. One physician in the town. Sixty-five miles from Louisville, Kentucky. Contact Mr. Virgil Taylor, Secretary, Chamber of Commerce, Mitchell 47446.

Continued

Madison—ELWOOD—population 11,800—surrounding area population 20,000. Need for general practitioners; 70-bed Catholic hospital. Office available. Located 38 miles northeast of Indianapolis and 20 miles from Anderson. Contact Marion C. Drake, M.D., State Road 13 South, or E. J. Tapek, Mercy Hospital, Elwood 46036. Telephone 522-3336.

Marshall—ARGOS—population 1,300. Located in the northern part of Indiana. Hospital facilities available at Plymouth—67-bed county hospital. Contact James N. Hampton, M.D., 530 N. Michigan, Argos 46501.

CULVER—population 1,700. Located in the lake region of northern Indiana. Home of Culver Military Academy. Fourteen miles from Plymouth. Opening for an associate or partner in general practice. Contact Joseph Howard, M.D., 921 Lake Shore Drive, Culver 46511.

PLYMOUTH—population 8,000 and a surrounding area of 15,000. Located in northern Indiana 25 miles from South Bend, 90 miles from Chicago and 125 miles from Indianapolis. Several small industries and good farming area. County hospital. Associate practice. Established practice. Well-equipped office. Contact James O. Coursey, M.D., 109 N. Walnut St., Plymouth 46563.

Montgomery—CRAWFORDSVILLE—Culver Union Hospital; 103-bed county hospital. Latest addition completed 1967. New facilities included in construction: x-ray, laboratory, O.B., emergency, surgery. Accredited by Joint Commission each year for last 12 years. Population 16,000. Home of Wabash College. Need for general practitioners. Medical Priorities Committee has been established. Contact Mr. C. Merrill Dailey, Chairman, Medical Priorities Committee, 1000 Fairview Ave., P.O. Box 272, Crawfordsville 47933. Telephone 362-2342 or 362-8942.

LINDEN—population 600. Located 10 miles from Crawfordsville where hospital facilities are available. Community can offer a general practitioner opportunities for success with a profitable and pleasant life. Contact Mr. Lloyd W. Faust, Linden Businessmen's Association, 414 South St., Linden 47955. Telephone 339-7708.

WAVELAND—population 500. Twelve miles from Crawfordsville. Lions Club interested in having a physician locate there. Contact Mr. J. Lowell Spencer, Waveland 47989.

Newton—LAKE VILLAGE—farming community with a surrounding population of 3,000. Closest physician located 12 miles distant. Hospital facilities are available at Brook, 20 miles away. Contact Mr. Bill H. Wright, Box 245, Lake Village 46349.

Parke—ROCKVILLE—population 2,500. Located in the west central part of Indiana. Hospital facilities available at Clinton which is 18 miles. Raccoon Lake State Recreation Area close by. Contact Richard S. Bloomer, M.D., Rockville 47872.

Porter—PORTAGE—population 16,490. Located in the northwestern part of Indiana (industrial section). Need for general practitioners. Contact Milton R. Carlson, M.D., Portage Clinic, 2674-P, Portage Mall, Portage 46368.

VALPARAISO—population 16,938. Porter Memorial Hospital has 230 beds. Located in the northwestern part of Indiana close to the Chicago area. Need for general practitioners. Contact Leo C. Noonan, M.D., 802 LaPorte Ave., Valparaiso 46383.

Posey—CYNTHIANA—population 600—located in the southwestern part of Indiana, 20 miles from Evansville where hospital facilities are available. The principal economies are agriculture and industrial employment. A non-profit corporation, Cynthiana Medical Center, Inc., has been formed. Contact E. F. Heiser, President or Miss Helen M. Martin, Secretary, Cynthiana 47612.

MT. VERNON—population 7,000—located close to Evansville. Doctor shortage has become acute. Posey County Medical Society and the Chamber of Commerce interested in securing physicians for the town and community. Contact Mrs. Bess L. Mangis, Ex. Secretary, Chamber of Commerce, 114 W. Fourth St., or Herman Hirsch, M.D., Secretary, Posey County Medical Society, Mt. Vernon 47620.

Putnam—GREENCASTLE—population 8,000. DePauw University is located in Greencastle, also Putnam County Hospital (84 beds). Need for general practitioners. Fully accredited hospital. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle 46135.

ROACHDALE—located in the west central part of Indiana. Principal economies are agriculture and industry. Located 16 miles from Greencastle, Danville and Crawfordsville and 35 miles

from Indianapolis where hospitals are located. Opening for one or two general practitioners. Medical center building which has been built from the plans and specifications of the Sears-Roebuck Foundation is available. Contact W. E. Etcheson, Jr., President, Community Medical Center, Inc., Box 121, Roachdale 46172. Telephone (317) 596-3911 or 596-5153.

Randolph—SARATOGA—population 350—located in a very prosperous farming community in the east central part of Indiana. Several industries located nearby. Two hospitals of 50 beds within seven miles. Contact Mr. Harold L. Girton, Saratoga 47382.

WINCHESTER—population 6,000 with a trade area of 12,000 to 15,000. Randolph County Hospital (60 beds) located in town. Agricultural and industrial community. Need for two or three general practitioners. Contact Mr. William Hunter, 111½ W. Washington St., C. R. Slick, M.D., 457 Elm St., Mr. Lacy C. Barnett, Administrator of the hospital, and Paul W. Sparks, M.D., 212 S. Main St., all of Winchester 47394.

Ripley—FRIENDSHIP—large rural area in need of a physician. Located close to Madison, Batesville and Lawrenceburg where hospitals are located. Contact Mrs. Henry D. Fisse, Friendship 47021.

OSGOOD—population 1,250. Located in the southeastern part of Indiana. Hospitals located at Batesville and Greensburg—18 miles. Principal economies are agriculture and industry. Contact Mr. Oran Gloyd, President, Osgood Lions Club, Osgood 47037.

Rush—CARTHAGE—population 1,026. Located in a rich farming area 14 miles from Rushville where hospital facilities are available. Northwestern part of county without the services of a physician. Office and equipment of the late Doctor McNabb available. Contact Mr. James Ellis and Mr. Frank Hampton, 307 N. Main St., Carthage 46115.

St. Joseph—NORTH LIBERTY—population 1,200. For sale or lease 1,200 square foot office building. Excellent opportunity for young doctor with limited amount of money to start practice. Equipment, drugs and supplies available. Going, active practice; no other physician in town. Fifteen miles from South Bend where hospitals are located. Con-

- tact O. Walter Calvin, M.D., 103 S. Eddy St., South Bend 46617.
- Spencer—ST. MEINRAD—located 50 miles northeast of Evansville and 75 miles from Louisville, Kentucky. Tri-state highway to be located close by. Population 800 with a large drawing area. Modern four room office available. Hospitals located in Huntingburg (17 miles) and Tell City (19 miles). Community provides an excellent future for anyone desiring a rural general practice. Contact Mr. Othmar Ringeman, St. Meinrad Development Corp., and Mr. Ottis N. Schatz, St. Meinrad 47577.
- Starke—KNOX—population 4,000—county seat. Located in the lake region of northern Indiana. Forty-bed hospital to be doubled in size. Five physicians in the county. Opening for general practitioner and anesthesiologist. Contact J. F. DeNaut, M.D., 4 N. Heaton St., Knox 46534.
- Steuben—ANGOLA—population 4,800—located in the extreme northeastern part of Indiana in the lake region. There are only 11 physicians for a population of 20,000. Furnished office available in the hospital. Contact Mr. Fred Schwerin, Administrator, Cameron Hospital, Angola 46703.
- FREMONT—population 937 with a 1970 projected census of 1,000. Population retail trading area 25,000. Located in the lake region of northeast Indiana three miles from the Indiana Toll Road and Interstate 69. Hospital facilities available at Angola, home of Tri-State College. Contact Harold Clark, Medical Service Committee, P. O. Box 26, Fremont 46737.
- Sullivan—CARLISLE—population 900. Located nine miles from Sullivan, county seat, where a 116-bed hospital is located. Hospital has been remodeled, new addition containing the latest in surgical equipment. Contact J. S. Brown, M.D., Carlisle, Secretary, Sullivan County Medical Society and Mrs. Josephine Ridgway, Carlisle, R. R. # 1, 47838.
- Switzerland—VEVAY—population 1,700. County seat town. Located close to Madison, Indiana on the Ohio River, midway between Cincinnati, Ohio and Louisville, Kentucky. The people of the community have helped expand facilities of the one full time physician to provide space for another physician or will be willing to help provide separate facilities. New industry coming to community. Contact Mr. H. C. Benedict, Superintendent, Switzerland County Schools, Vevay or Mr. Raymond Osborn, Jr., Vevay 47043.
- Union—LIBERTY—population 1,750. Located in the east central part of Indiana. Principal economies are agriculture and industry. Hospitals at Richmond (18 miles) and Connersville (12 miles). Contact Mr. P. A. Smith, Superintendent, Union County School Corporation, P. O. Box 188, Liberty 47353.
- Vanderburgh—DARMSTADT—Village Square Shopping Center located six miles from Evansville. Three hospitals in Evansville. Space available for an office. Need for general practitioner or internist. Growing community with approximately 1,800 homes and 7,000 persons in a four-mile area. Prescription drug store in complex. Contact Robert L. Willner, R. R. # 5, Box 117, Evansville 47710.
- Vermillion—CLINTON—population 5,850. Located in west central part of Indiana. Vermillion County Hospital (72 beds). Three physicians in the community. Contact Milton Herzberg, M.D., 222 Elm St., Clinton 47842.
- PERRYSVILLE—population 500. Located in a rich farming area along the Wabash River. Fifteen miles from Danville, Illinois and 25 miles from Clinton, Indiana where hospitals are located. Contact Mrs. Sara M. Sheridan, Perrysville 47974.
- Warrick—BOONVILLE—population 5,000. Located 15 miles from Evansville where hospital facilities are available. There is a need for general practitioners in Boonville. Only six physicians in the county. Contact Don Julian, Julian's Rexall, Boonville 47601.
- NEWBURGH—population 1,350. Located five miles from Evansville. Contact Mrs. Frank Jones, Newburgh 47630.
- Wayne—CAMBRIDGE CITY—population 2,600 with a surrounding area of 8,000. Fully equipped office available. Hospitals at New Castle (194 beds), Richmond (367 beds) and Connersville (109) within a 15 mile radius. Contact Robert A. Cox, D.D.S., 3 Parkview Court, Cambridge City 47327. Telephone 35191.
- MILTON—population 800. Community without a physician. Located close to Richmond. Office available. Contact Mr. Oscar Fain and Mr. and Mrs. Irvin Lemmons, 308 Central Ave., Milton 47357.
- RICHMOND—population approximately 50,000. There is a need for several physicians who are interested in doing general practice. Reid Memorial Hospital (367 beds) located there; also Earlham College. Modern and thriving city located in east central Indiana. Contact either Darwood Hance, M.D., % Reid Memorial Hospital or William R. Stilwell, M.D., 2607 South C Place, Richmond 47374.
- White—CHALMERS—population 500. Located in the northwestern part of Indiana in an agricultural area. Twelve miles from Monticello where the White County Memorial Hospital (48 beds) is located. Contact Charles M. Barget and John Tully, Chalmers 47929.
- MONON—population 1,500. Located close to Lafayette and Monticello where hospitals are located. Contact Thad Hanway, 121 S. Market, Monon 47959.
- MONTICELLO—population 6,000. County seat town with a 48-bed county hospital. Contact Richard J. Reichow, Administrator, White County Memorial Hospital, Monticello 47960.
- Whitley—CHURUBUSCO—population 2,000 with a surrounding trading area of 10,000. Located 10 miles from Columbia City and 14 miles from Fort Wayne where hospitals are located. Fully equipped office available. Contact Mr. R. J. Krider, Churubusco 46723.
- SOUTH WHITLEY—population 1,500. Located between Fort Wayne, Huntington and Columbia City where hospitals are available. Closest hospital is at Columbia City, 10 miles away. Lake region of Indiana. Office available. Contact Mrs. Tom Newell, Secretary, Chamber of Commerce and Mr. Howard F. Clark, Jr., Clark Drugs, Inc., South Whitley 46787.

OPENINGS FOR SPECIALISTS IN INDIANA

ANESTHESIOLOGY

- Jefferson—MADISON—population 10,500. Located in southern Indiana on the Ohio River. Hospital—109 bed. Contact Keith Sloan, M.D., 426 E. Main St., Madison 47250.
- Shelby—SHELBYVILLE—population 15,000. Opening at Inlow Clinic or W. S.

Major Hospital (110 beds). Contact Robert P. Inlow, 103 W. Washington St., Shelbyville 46176. For additional locations see Grant County—Marion, Indiana, and Wells County—Bluffton, Indiana.

ALLERGY

Lake—GARY—population 178,320. Opening to join a 24-man clinic. New clinic building with complete x-ray and laboratory facilities. Two excellent open staff hospitals. Contact R. Lyle Fosler, The Gary Clinic, 6111 Harrison St., Gary 46408.

DERMATOLOGY

Grant—MARION—population 38,000. General hospital—244 beds. Opening at Davis Clinic, 131 N. Washington St. Contact Joseph B. Davis, M.D., 131 N. Washington St., Marion 46952.

EAR, NOSE AND THROAT

Floyd—NEW ALBANY—population 38,000. Located in southern Indiana across the Ohio River from Louisville, Kentucky. Opportunities for solo practice or associate. Memorial Hospital, with 210 beds, located there. Contact Daniel H. Cannon, M.D., Secretary, Floyd County Medical Society, 1201 E. Spring St., New Albany.

Hamilton—NOBLESVILLE—population 7,500. Located 25 miles north of Indianapolis. County hospital (86 beds) located there. Opening for ear, nose and throat practice—no specialist in area. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville 46060.

Knox—VINCENNES—population 20,000. Located in southwestern Indiana, with a 227-bed hospital. Contact E. R. Cantwell, M.D., 202 Broadway St., Vincennes 47591.

Porter—VALPARAISO—population 16,938. Porter Memorial Hospital has 230 beds. Located in the northwestern part of Indiana close to the Chicago area. Contact Martin J. O'Neill, M.D., 1101 Glendale, Valparaiso 46383.

INTERNAL MEDICINE

Delaware—MUNCIE—population 70,000. Opening at Muncie Clinic. Ball Memorial Hospital (465 beds) with additional construction. Ball State University with 12,000 students located in Muncie. Contact W. F. Kammer, M.D., 420 W. Washington St., Muncie 47305.

Grant—MARION—population 38,000. General Hospital—244 beds. Opening at Davis Clinic, 131 N. Washington St. Contact Joseph B. Davis, M.D., 131 N. Washington St., Marion 46952.

Lake—GARY—population 178,320. Opening at Gary Clinic, 6111 Harrison St., Gary. See Gary, Indiana under Allergy for details. Contact R. Lyle Fosler, The Gary Clinic, 6111 Harrison St., Gary 46408.

Huntington—HUNTINGTON—a town of 17,000 with a new 100-bed hospital. Huntington is in the center of a new recreational area with three large reservoirs. Contact Paul E. Doermann, M.D., 1775 N. Jefferson, Huntington 46750—telephone (219) 356-4520 or Wayne S. Miller, M.D., 610 N. Jefferson St., Huntington 46750.

Marshall—PLYMOUTH—population 8,000 and a surrounding area of 15,000. Located in northern Indiana 25 miles from South Bend, 90 miles from Chicago and 125 miles from Indianapolis. Several small industries and good farming area. County hospital—67 beds. Contact James S. Robertson, M.D., 304 N. Walnut St., James F. Rimmel, M.D., and Lloyd C. France, M.D., 1223 N. Center St., Plymouth 46563.

Porter—PORTAGE—population 16,490. Located in the northwestern part of Indiana (industrial). Contact Milton R. Carlson, M.D., Portage Clinic, 2674-P, Portage Mall, Portage 46368.

VALPARAISO—population 16,938. Porter Memorial Hospital has 230 beds. Located in the northwestern part of Indiana close to the Chicago area. Contact Martin J. O'Neill, M.D., 1101 Glendale, Valparaiso and Leo C. Noonan, M.D., 802 LaPorte Ave., Valparaiso 46383.

Putnam—GREENCASTLE—population 8,000. Home of DePauw University. County seat town with a fully accredited 84-bed county hospital. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle 46135.

Wells—BLUFFTON—population 8,500. Opening at Caylor-Nickel Clinic, a 35-man multispecialty clinic. Clinic Hospital—188 beds. Contact W. E. Symon, M.D., 303 S. Main St., Bluffton 46714.

OBSTETRICS AND GYNECOLOGY

Floyd—NEW ALBANY—population 38,000. Located in southern Indiana across the Ohio River from Louisville,

Kentucky. No Ob-Gyn physician in town. Memorial Hospital has 210 beds. Contact Daniel H. Cannon, M.D., Secretary, Floyd County Medical Society 1201 E. Spring St., New Albany.

Porter—PORTAGE—population 16,490. Located in the northwestern part of Indiana (industrial section). Contact Frank M. Sturdevant, M.D., Portage Clinic, 2674-P, Portage Mall, Portage 46368.

OPHTHALMOLOGY

Grant—MARION—population 38,000. General Hospital—244 beds. Opening at Davis Clinic, 131 W. Washington St. Contact Joseph B. Davis, M.D., 131 N. Washington St., Marion 46952.

Hamilton—NOBLESVILLE—population 7,500. Located 25 miles north of Indianapolis. County hospital—86 beds. Opening for ophthalmology practice—no specialist in the area. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville 46060.

Knox—VINCENNES—population 20,000. Contact E. R. Cantwell, M.D., 202 Broadway St., Vincennes 47591.

Lake—GARY—population 178,320. Opening to join a 24-man clinic. Two excellent open staff hospitals. Contact R. Lyle Fosler, The Gary Clinic, 6111 Harrison St., Gary 46408.

Putnam—GREENCASTLE—population 8,000. Home of DePauw University. County seat town with a fully accredited 84-bed county hospital. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle 46135.

Wells—BLUFFTON—population 8,500. Opening at Caylor-Nickel Clinic, a 35-man multispecialty clinic. Clinic Hospital—188 beds. Contact D. W. Meier, M.D., 303 S. Main St., Bluffton 46714.

ORTHOPEDICS

Grant—MARION—population 38,000. Contact Joseph B. Davis, M.D., Davis Clinic, 131 N. Washington St., Marion 46952.

Hamilton—NOBLESVILLE—population 7,500. No orthopedic specialist in area. County hospital—86 beds. Contact Haldon C. Kraft, M.D., 195 S. 10th St., Noblesville 46060.

Lake—GARY—population 178,320. Opening at Gary Clinic, a 24-man clinic. Two excellent open staff hospitals. Contact R. Lyle Fosler, Gary Clinic, 6111 Harrison St., Gary 46408.

Wells—BLUFFTON—population 8,500. Opening at Caylor-Nickel Clinic, a 35-man multispecialty clinic. Clinic Hospital—188 beds. Contact D. W. Meier, M.D., and William E. Symon, M.D., 303 S. Main St., Bluffton 46714.

PATHOLOGY

Porter—VALPARAISO—population 16,938. Located in the northwestern part of Indiana close to the Chicago area. Porter Memorial Hospital has 230 beds. Contact Leonard Z. Sacks, M.D., Porter Memorial Hospital, Valparaiso 46383.

PEDIATRICS

Delaware—MUNCIE—population 70,000. Opening for physicians specializing in pediatrics; 12,000 student Ball State University located in Muncie. Ball Memorial Hospital—465 beds with additional construction. Contact W. F. Kammer, M.D., 420 W. Washington St., Muncie Clinic, Muncie 47305.

Knox—VINCENNES—population 20,000. Located in southwestern Indiana. Good Samaritan Hospital—227 beds. Contact Thomas Barrett, M.D., 305 S. Fifth St., Vincennes 47591.

Lake—GARY—population 178,320. Opening at Gary Clinic, a 24-man clinic. Two excellent open staff hospitals. Contact R. Lyle Fosler, Gary Clinic, 6111 Harrison St., Gary 46408.

Porter—PORTAGE—population 16,490. Located in the northwestern part of Indiana (industrial section). Contact Milton R. Carlson, M.D., Portage Clinic, 2674-P, Portage Mall, Portage 46368.

Wells—BLUFFTON—population 8,500. Opening at Caylor-Nickel Clinic, a 35-man multispecialty clinic. Clinic Hospital—188 beds. Contact William E. Symon, M.D., 303 S. Main St., Bluffton 46714.

Putnam—GREENCASTLE—population 8,000. Pediatrician needed in Greencastle. Contact J. B. Johnson, M.D., 105 E. Washington St., Greencastle 46135.

PSYCHIATRY

Jefferson—MADISON—population 10,500. Opening for two psychiatrists at Madison State Hospital (1,500 beds). Contact O. B. McAtee, M.D., Superintendent, Madison State Hospital, Madison 47251.

Lake—GARY—population 178,320. Opening to join a 24-man clinic. New clinic building with complete x-ray and laboratory facilities. Two excellent open

staff hospitals. Contact R. Lyle Fosler, The Gary Clinic, 6111 Harrison St., Gary 46408.

Porter—PORTAGE—population 16,490. Located in the northwestern part of Indiana. Contact Frank M. Sturdevant, M.D., Portage Clinic, 2674-P, Portage Mall, Portage 46368.

Wells—BLUFFTON—population 8,500. Opening at Caylor-Nickel Clinic, a 35-man multispecialty clinic. Clinic Hospital—188 beds. Contact W. E. Symon, Caylor-Nickel Clinic, 303 S. Main St., Bluffton 46714.

SURGERY

Grant—MARION—population 38,000. General Hospital—244 beds. Opening at Davis Clinic. Contact Joseph B. Davis, M.D., 131 N. Washington, Marion 46952.

Jefferson—MADISON—population 10,500. Located in southern Indiana on the Ohio River. King's Daughter's Hospital—109 beds. Contact Frank Hare, M.D., 722 W. Main St., Madison 47250.

UROLOGY

Knox—VINCENNES—population 20,000. Located in southwestern Indiana. Good Samaritan Hospital—227 beds. Contact W. R. Vaughn, M.D., 615 Dubois Street, Vincennes 47591. ◀

★
Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTION COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller, Representative

665 East 61st Street

Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

MAKE YOUR ROOM RESERVATIONS NOW!

for the 118th

Annual Convention of the

Indiana State Medical Association

House of Delegates opening session

2:00 p.m., Monday, October 9, 1967

	Single	Double and Twins	Suites
Antlers Hotel 750 N. Meridian	6.50 - 10.00	11.00 - 13.00	
Claypool Hotel 14 N. Illinois	8.50 - 12.00	14.00 - 18.00	35.00 - 50.00
Sheraton-Lincoln 117 W. Washington	8.50 - 11.85	14.85 - 15.85	32.00 - 52.00
Marott Hotel 2625 N. Meridian	9.00 - 15.00	13.00 - 18.00	30.00 - 50.00
Stouffer Inn 2820 N. Meridian	12.00 - 20.00	16.00 - 26.00	26.00 - 40.00
Holiday Inn 500 W. Washington	11.00 - 12.00	15.00 - 16.00	20.00, 25.00
Holiday Inn 1920 N. Meridian	11.00	12.00	20.00
Howard Johnson's 501 W. Washington	11.00 - 18.00	12.50 - 16.00	20.00, 25.00

* Rates subject to change

YOU ARE ADVISED TO REQUEST RESERVATIONS
EARLY TO ASSURE YOU OF YOUR CHOICE OF
HOTEL AND ACCOMODATIONS

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Surgeon not Liable for Severing of Patient's Spinal Accessory Nerve—A patient was not entitled to recover damages in a suit against a surgeon for his alleged negligence in having severed her spinal accessory nerve during an operation for the removal of two enlarged malignant glands from the left side of her neck. The evidence was insufficient to establish any negligence on the surgeon's part, the North Carolina Supreme Court ruled.

The glands were removed so that a biopsy could be made to aid the patient's attending physician in his diagnosis of her condition. The pathologist who performed the biopsy testified that the glands were intact and had been perfectly removed. The testimony by medical experts for both parties established that: the utmost care was required in the removal process to protect the glands' outer covering because of the danger of spreading the infection or malignancy if the covering were broken; the accessory nerve is very small and its course is indefinite and wandering in the area of the operation; in the final stage of the operation, the diseased glands, because of their enlargement, have to be lifted up and separated from the surrounding tissue without a good view of the bottom of the gland. A medical witness for the surgeon testified that the severing of the accessory nerve was an inherent risk in the

operation, regardless of the surgeon's skill and care.

Lentz v. Thompson, 152 S.E.2d 107 (N.C., Jan. 20, 1967).

Patient's Lack of Capacity to Consent not Proved—A patient was not entitled to recover damages in a suit against a physician for his allegedly unauthorized performance of a septal reconstruction, where there was not sufficient evidence to overcome the presumption that the patient was competent when he gave his consent to the operation, the Washington Supreme Court ruled.

The patient, who had been hospitalized for other reasons, complained to his attending physician about his nose and his difficulty in breathing through one nostril. When the physician examined the patient on April 16, at the request of the attending physician, he found an external nasal deformity which was obstructive to breathing. He told the patient that corrective surgery should be performed. The patient agreed. On April 17, the patient's attending physician discussed the proposed surgery with the patient, and the patient again gave his oral consent. The physician again discussed the operation with the patient on April 18, and April 20 was chosen as the date for it. On April 19, a hospital nurse obtained the patient's written consent to the operation. The operation was performed on April 20.

The patient contended that his

consent was invalid because he was under the influence of drugs when he gave it, and that the performance of the operation was therefore an assault and battery.

The law presumes that a man is fully competent until satisfactory proof to the contrary is presented. The standard of proof required to overcome the presumption is that of clear, cogent, and convincing evidence.

A friend who visited the patient testified that he did not act like himself and appeared to be under the influence of drugs. The patient's wife testified that he did not act like himself and was deeply depressed and uncommunicative. The patient testified that he did not remember many details of his hospitalization, but said that he remembered the time just before the operation and that he was awake when it was performed. The hospital chart showed that the patient was deeply depressed and emotionally distraught and that he was given various dosages of morphine, Librium, Carbital and Parnate. There was evidence that Parnate produces harmful side effects when used in conjunction with sedatives and narcotics. The patient's attending physician testified that the Parnate did not seem to affect the patient and that the drugs he was given should have improved his reasoning power by lifting him out of his depression. Both the attending physician and the physician stated that

when they saw the patient he was depressed but not so emotionally distraught as to be incapacitated. The evidence established that the patient was deeply depressed, but it was not sufficient to overcome the presumption that he comprehended the nature, terms, and effect of his consent to the operation, the court said.

Grannum v. Berard, 422 P.2d 812 (Wash., Jan. 19, 1967).

Drug Manufacturer not Required to Bring Records to State Where Suit Brought—In a suit against a physician and the manufacturer of Kantrex by a patient for damages caused by taking the drug, a trial court erred in ordering the manufacturer to produce, in Colorado, its records relating to the development and testing of the drug for inspection and copying by the patient, the Colorado Supreme Court ruled.

Evidence presented by the manufacturer established that compliance with the order would involve annoyance, embarrassment or oppression. The order was amended to provide that the patient's inspection and copying of documents, except those claimed to be confidential or to contain trade secrets, should be done at the manufacturer's offices in New York. The documents containing confidential material or trade secrets were ordered sent to the trial court, where appropriate steps were to be taken to preserve their secrecy. The patient could not shift the financial burden of preparing his case to the manufacturer. He was therefore ordered to pay all reasonable expenses connected with the production, inspection, and copying of the records as they were incurred. Whether all or part of those expenses would ultimately be recoverable as costs would not be determined now, the court said.

Bristol Myers Company v. District Court in and for the City and County of Denver, 422 P.2d 373 (Colo., Jan. 3, 1967).

Damages in Suit for Death from Incompatible Transfusion not Excessive—In a suit against a hospital for the death of a patient as the result of the transfusion of incompatible blood, a trial court erred in setting aside, as excessive, the jury's award of damages and ordering a new trial on the damage issue, a Florida appellate court ruled.

The patient, who had Type O blood, was given two pints of Type A blood during prostate surgery. Kidney failure and uremic poisoning developed. Despite constant treatment, the patient died 17 days later. The jury awarded \$50,000 for the patient's pain and suffering before death, and \$125,000 to his widow for her damages resulting from his wrongful death.

The trial court gave as one reason for setting the verdicts aside that the improper "Golden Rule" argument had been made. The jury were merely told that only they could resolve the question of what amount of money would compensate the widow for her losses. That was not the equivalent of the "Golden Rule" argument which asks the jury to put themselves in the shoes of the person bringing the suit in deciding the amount of damages.

The fact that the hospital's insurance coverage was mentioned at the trial provided no basis for setting the damage awards aside. There was only a single mention of the coverage, it was elicited through cross-examination on the part of the hospital, and no objection was made at the time.

The record did not support the trial court's statement that the majority of the patient's pain was caused by the operation, not the improper transfusion. There was the contrary evidence that pain from the prostate operation would last only 24-48 hours after the operation, and that everything done for the patient during the 17 days before he died was directly related to the improper transfusion.

There undoubtedly was, as the trial court stated, considerable testimony about blood and the effect of an incompatible blood transfusion. However, it did not see how that could be remedied on a new trial, the court said. Further, there was nothing indicating that any undue or improper emphasis had been placed on those features of the case.

In the light of the evidence and by comparison with awards in other cases, the \$50,000 award for the patient's pain and suffering could not be considered excessive, the court said. The patient was conscious during most of the 17 days and his pain and suffering were severe.

The award of \$125,000 to the widow was not excessive, even though her pecuniary loss for loss of support and dower had a present value of only \$25,000. She lost her husband's services, his companionship, their marital relation, and their station in society. The award of \$100,000, or \$7,142 a year, for those losses could not be regarded as exceeding allowable limits, the court said.

Ward v. Orange Memorial Hospital Association, Inc., 193 So.2d 492 (Fla., Dec. 30, 1966; rehearing denied, Jan. 20, 1967).

Hospital Liable for Fracture of Patient's Arm—Damages could be recovered in a suit against a hospital by a patient who sustained a fracture of the humerus while in a comatose condition following a hysterectomy, the Montana Supreme Court ruled.

The operation was performed on February 20. Her recovery from the surgery was quite normal but, because of drugs she was given for pain, she was not fully aware of the circumstances and conditions around her. Late in the afternoon of February 22, she experienced two grand mal seizures within a period of less than 30 minutes. Only the patient's husband was in the room when the first seizure started. He immediately summoned help. A physician made

two examinations of the patient after the seizures subsided and found no evidence of any injury. At 1 a.m. on February 23, a nurse noticed severe swelling and bruises on the patient's right shoulder. X-rays taken at 8 a.m. disclosed a comminuted fracture of the right humerus.

No one was able to state how or when the injury occurred. The physician who examined the patient after the seizures testified that the injury had to have happened during the period between 9 p.m. when he completed the second examination, and 1 a.m. However, during that period she was constantly attended and no unusual incident occurred. There was considerable variation in the medical testimony as to how long it would take an injury such as the patient sustained to manifest itself through swelling and discoloration.

The instruction on the doctrine of *res ipsa loquitur* was properly given. There was evidence of the necessary elements of the doctrine, which are: the accident was of the kind that does not ordinarily occur in the absence of negligence; the injury was caused by an agency or instrumentality within the exclusive control of the hospital; the accident was not caused or contributed to by any voluntary action of the patient. The patient was not required to establish what the thing or instrumentality was that caused the injury.

The trial court did not err in instructing the jury that the nurses were the agents of the hospital. It was clear from the evidence that they were acting under the direction and control of the hospital.

Gormley v. Montana Deaconess Hospital, 423 P.2d 301 (Mont., Jan. 11, 1967; rehearing denied, Feb. 21, 1967).

Hospital Liable for Fall in Entranceway—A private nurse was entitled to recover damages in a suit against a hospital for injuries sustained when she slipped and fell on the terrazzo floor at the hospital's emergency entrance, while accom-

panying her patient into the hospital, the Pennsylvania Supreme Court ruled.

The nurse was a business invitee to whom the hospital owed the duty of maintaining its premises in a reasonably safe condition. It was a rainy night and the janitor had removed the rubber mat usually kept on the entranceway in order to remove the water that had accumulated. The nurse entered and fell before the janitor was able to mop up the water in the area. This evidence was sufficient to support the jury's finding that the hospital janitor had created a dangerous condition which had caused the nurse's fall. The fact that the janitor was carrying on the mopping in plain view did not relieve the hospital from liability because the nurse's view was blocked by the litter carrying her patient that was preceding her through the entranceway.

Kerwood v. Rolling Hill Corporation, 225 A.2d 918 (Pa., Jan. 20, 1967).

Physician not Liable for Amputation of Finger—A patient whose right index finger, which had been severely lacerated, had to be amputated when gangrene developed was not entitled to recover damages in a suit against the physician who originally treated the laceration, the Utah Supreme Court ruled.

The patient sustained the laceration while he was on vacation. The laceration severed the bone in the middle phalanx as well as the muscles, tendons, nerves and blood vessels supplying the finger. At the time of treating the laceration, the physician said that he was trying to effect a bone graft in the hope that the finger could be saved. When he returned home four days later, the patient consulted his family physician. When the bandage was removed, the finger was found to be black, without feeling or sensation. The finger was amputated.

The family physician testified that the gangrene had been caused by the

constrictive type of bandage that had been applied, and that the finger should have been a normally functioning finger if it had been properly treated. On cross-examination, he conceded that in his pretrial deposition he had said that the finger had been almost completely amputated by the injury and that any physician would have felt fortunate in getting a normally functioning finger from it. He then said that if he had treated the patient when the laceration occurred, he would have recommended amputation at that time, but that such a decision was a matter for the judgment of the treating physician.

Since there was no evidence that the physician failed to meet the community standard of care in his treatment of the patient or that any negligence on his part was the proximate cause of the ultimate result, he could not be held liable. The family physician testified that there was a possibility that the finger might have been saved if other treatment had been used, but he also testified that amputation would, in all probability, have been required inasmuch as the bone had already been amputated. Thus any jury verdict for the patient could have been based on only conjecture or speculation.

Dickinson v. Mason, 423 P.2d 663 (Utah, Feb. 8, 1967).

Hospital Incident Report Protected from Discovery Procedure by Privilege—In a suit for damages by a patient against a hospital and a physician for injuries caused by their allegedly negligent treatment, a trial court erred in ordering the hospital to produce an incident report, relating to the patient's treatment, for inspection by her attorney, a California intermediate appellate court ruled.

The report was made by the hospital administrator on the basis of information furnished by the director of its nursing service. It was made on the form provided by the hospital's liability insurer. The purpose in making the report was to prepare

to defend the hospital in the event that the patient should file suit. The preparation of such reports was one of the normal duties of the administrator. He sent it to the liability insurer which sent it to the attorney that had been retained to defend the hospital in the patient's suit against it.

The discovery statute provides for the production and inspection of only those documents that are "not privileged." The term "not privileged" refers to "privileges" as that word is understood in the law of evidence. In its opinion, the report was within the attorney-client privilege and thus not subject to discovery, the court said. That the hospital was a corporation was immaterial. A corporation is entitled to the same protection under the attorney-client privilege that a natural person has. The report's privileged status was not destroyed by the fact that it was sent to the attorney through the agency of the hospital's liability insurer.

Sierra Vista Hospital v. Superior Court of the State of California for the County of San Luis Obispo, 56 Cal. Rptr. 387 (Cal., Feb. 6, 1967).

Maintenance Company Liable for Injuries Sustained During Escape from Stalled Hospital Elevator—A hospital employee was entitled to recover damages in a suit against an elevator maintenance company for injuries sustained when she tried to escape from a stalled elevator through the means of escape provided by hospital employees, a New York trial court ruled.

When the elevator stalled between the second and third floors, it was carrying 11 persons and a portable EKG machine. The hospital engineer was called on the telephone in the elevator car. He and two other hospital employees arrived at the car 25-30 minutes after it had stalled. They were able to open the shaft doors on the third floor and lower a ladder into the car. The employee, while climbing the ladder, lifted her

head and struck the top of the car, fracturing her skull.

The evidence established that the stalling of the elevator was caused by the elevator company's negligence in maintaining it. Its negligence was the proximate cause of the employee's injuries. It could reasonably have been foreseen that, in the event of a breakdown of the elevator, steps would be taken by the hospital's own employees to rescue any passengers, and that injuries might occur in the course of the rescue. It could reasonably have been foreseen that the hospital employees would not remove the two escape doors to accomplish the rescue as the elevator company's experts would have. Even if the hospital employees knew of the doors' existence, it could reasonably be expected that they would not take the time to remove them. The employee's use of the escape route provided did not constitute contributory negligence. In view of the crowded condition of the elevator, the length of time it had been stalled, and the air of hysteria that had developed, it could not be said that a person of ordinary prudence would not have done so.

Hoggard v. Otis Elevator Co., 276 N.Y.S.2d 681 (N.Y., Dec. 30, 1966).

Physician Liable in Patient's Suit for Injuries Following Injection—A patient, who had a defect in his leg muscles following an injection of Erythromycin, was entitled to recover damages in a suit against the physician who administered the injection, the Supreme Judicial Court of Massachusetts ruled.

There was evidence that the injection was given close to the center of the patient's left buttock and in a place in its lower portion. There was expert testimony that: giving an injection in that place involved some, although not a very great, avoidable risk to the sciatic nerve which could result in a leg muscle defect; common and accepted local practice required making an injection in the upper outer quadrant of the buttock

to avoid that risk; failure to avoid that risk could be negligence. That evidence, together with evidence that there was a causal connection between the injection and the patient's injury, was sufficient to support the jury's verdict in favor of the patient.

Johnson v. Phillips, 223 N.E.2d 677 (Mass., Feb. 2, 1967).

Ruling Issued on Tax Treatment of Professional Fees Received by Faculty Members—

A ruling as to the treatment, for federal income tax purposes, of fees received by the full-time faculty members of a medical school from private professional practice and turned over to the school, pursuant to the member's contract of employment, has been issued by the Internal Revenue Service.

Two basic plans for compensating faculty members are operated by the school. Faculty members enrolled under Plan 1 are required to turn over promptly to the school all fees from private professional practice. Those enrolled under Plan 2 can retain fees from private professional practice up to an amount which in any calendar year equals, before income taxes, their salary plus legitimate professional expenses for the year, and turn over anything in excess of that amount to the school. When the faculty members engage in private professional practice, they are not acting as agents of the school. Therefore, the faculty members must include in gross income the fees received from such practice. The amount of fees received which is actually turned over to the school by a faculty member is deductible by him as an ordinary and necessary business expense.

Rev. Rul. 66-377, I.R.B., 1966-52, p. 5.

Drug Manufacturer Liable to Patient for Loss of Vision—A patient, who lost 80% of her vision as the result of having taken Aralen for six years, was entitled to recover damages in a suit against the manu-

facturer of the drug, a federal trial court in South Dakota ruled.

The patient began to use the drug in 1958. In 1960, the manufacturer's product card for the drug warned of possible retinal vascular response and in 1962, it warned of possible retinal damage. The *Physician's Desk Reference* indicated in 1963 that there had been reports of rare and irreversible retinal changes from the use of the drug. In 1963, the manufacturer sent physicians a letter advising them that complications had been reported during prolonged daily use of the drug. The manufacturer's detailman did not bring the side effects of the drug to the attention of the patient's physician.

The manufacturer did not give sufficient warning of the drug's side effects. In view of the flood of literature a physician receives from the various drug manufacturers as to their many products, a change in the literature or an additional letter intended to present new information on a drug to the physician does not constitute a sufficient warning. The evidence showed that the use of detailmen is the most effective method employed by drug manufacturers in the promotion of new products. This would also be the most effective method of warning physicians about recent developments in drugs already in use and could be done at no great additional expense to the manufac-

turer. The manufacturer's failure to use this means of informing the patient's physician of the drug's side effects was negligence, and it was liable to the patient for the injuries caused by that negligence.

There was no question of intervening proximate cause in the case. Since the manufacturer was negligent in not giving sufficient warning of the drug's side effects, it was liable without regard to anything that the physician may or may not have done.

Yarrow v. Sterling Drug, Inc., 263 F. Supp. 159 (D.C., S.D., Jan. 25, 1967).

Physicians Exonerated in Patient's Suit for Radiation Injuries

—In a suit for damages against a urologist and a radiologist by a patient who sustained skin burns and an ulceration as a result of radiation treatments administered by the radiologist, a verdict in favor of the urologist and the radiologist was directed by an Illinois trial court. The urologist referred the patient to the radiologist after his left testicle had been removed because of seminoma. The patient claimed that his consent to the radiation treatments was not an informed consent. The urologist and the radiologist took the position that the side-effects of the treatments were unimportant because the treatments were necessary to save the patient's life.

Fortino v. Calams, Cir. Ct., Cook Co., Docket No. 62 S 4709 (Ill., Dec. 19, 1966).

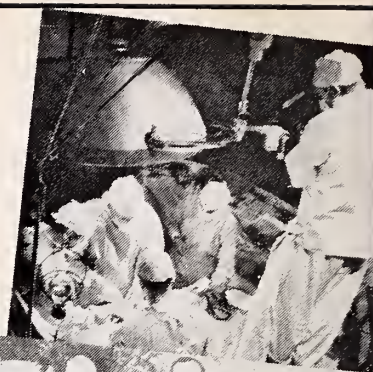
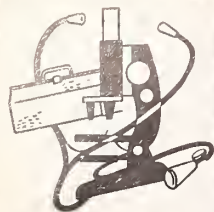
Physician and Hospital Properly Joined in Suit for Wrongful Death of Patient

—In a suit for damages for the wrongful death of a patient following his admission to a hospital for treatment of gunshot wounds, the hospital and a physician were properly joined as parties, the North Carolina Supreme Court ruled.

The complaint alleged that: the physician, with knowledge of the seriousness of the patient's condition, failed to administer any treatment; the hospital, with knowledge of the seriousness of the patient's condition and of the physician's failure to administer treatment, failed to administer any treatment; the joint and concurrent negligence of the physician and the hospital in failing to provide the patient with the proper treatment, which could have saved his life, was the proximate cause of his death.

The complaint alleged a single cause of action for the death of the patient as the result of the joint and concurrent negligence of the physician and the hospital in failing to provide him with the proper care and treatment. Parties may be joined where their related and concurring negligent acts have produced a single injurious result.

McEachern v. Miller, 151 S.E.2d 209 (N.C., Nov. 30, 1966). ◀



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

ABSTRACTS

BOOK REVIEWS

ETHICS IN MEDICAL PROGRESS

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Maeve O'Connor, Little, Brown & Co., Boston, Mass., 1966; 257 pages; \$11.75.

More than two dozen theologians, lawyers and M.D.'s discuss the new problems in medical ethics (especially as applicable to transplants) raised by the completely new vista being opened by our newer technics.

Who has to obtain whose consent for procedures still not fully accepted? How much should the recipient—and donor—be told? How about the use of kidneys from individuals dead of non-renal causes? And: just what do we mean today by "death"? Is a beating heart, forced by a pacemaker, a sign of life? We can keep the lungs working and the heart beating long after an E. E. G. ceases to show any electrical activity in the brain. Are we not dealing in this case with an artificial heart-lung preparation in an individual who is truly dead from the moment the E.E.G. shows only the inert base line?

The discussions are most thought provoking. There are also no less than SIX appendices: 1) the Nuremberg Code, 2) the Declaration of Helsinki, 3) Declaration of Geneva, 4) Statement of Pope Pius XII on "reanimation", 5) Human Tissue Act of 1961, 6) D. of Columbia Tissue Bank Act, 1962. Their juxtaposition is silent witness to the perplexities facing our collective consciences and withheld judgments.

As medicine progresses, the questions being posed will only grow in scope. This symposium is a good start for us all: it is deserving of repeated readings. Our collective juries will make interim judgments that will be guidelines not only for us but to succeeding generations.

The high quality of the paper, binding and printing continues up to the highest standards.

ARNOLD LIEBERMAN, M.D.
New York, New York

A COMPLETE GUIDE FOR THE WORKING MOTHER

Margaret Albrecht, Doubleday and Company, Inc., New York, 1967; 335 pages; \$4.95.

Here is a book to which the working mother may be referred for self-help or a book to which the physician may refer to give advice. The book is divided into nine sections:

1. Introductory—estimates number of working mothers, lists reasons for working.
2. Work and marriage—how the husband feels about a working wife, "dual or duel income", sex.
3. Working mother and widowhood.
4. The children—what about maternal deprivation, saving time to spend with the children.
5. The children—baby sitter problems.
6. The job—how to get ahead and make work more productive.
7. The home—how to keep it on budgeted time and income.
8. Money—how to manage it and financial-legal matters.
9. The woman—discusses how to be a complete woman by saving time from the job and home for self.

The book is easy to read and the contents set up for easy

reference. It is well documented for such a book—it lists six and one-half pages of recent references to other books, pamphlets and articles in the bibliography.

ALVIN J. HALEY, M. D.
Fort Wayne

YOU ARE AS YOUNG AS YOUR SPINE

Editha Hearn, Doubleday & Company, New York, 1967; 120 pages; \$4.50.

This small volume is a manual of instructions on the care of the back. It presents much practical information, not only for physicians, but also for that large segment of patients who suffer from backache, neck pain, sciatica and associated discomforts. Although most lower back pain is caused by fatigue or strain, the author states that 80 to 90% of adults suffer, at some time or other, from dislocations of the intervertebral discs.

Since we no longer require strong muscles to obtain food or to protect ourselves from other animals, increased strain has been placed on the joints of the spine. One heritage of man's achievement of the erect position is spinal compression strain. The intervertebral discs may break or slip forward or backward. Most movements involve some flexion of the spine; as a result the disc frequently slips backward causing pressure on the dura and nerve roots. The discs most frequently broken or displaced are those at the bottom of the load, the lower lumbar region.

The first chapter of the book describes the anatomy of the spinal column. This material is clearly presented with some simple diagrammatic sketches.

The author is a physiotherapist who has been trained by Dr. James Cyriax, orthopedic surgeon to St. Thomas Hospital, London, an authority on disc problems. The recommended preventive and curative measures have nothing to do with osteopathic or chiro-



...THEY
CAN
WALK
AGAIN

• Torpedoed on the Murmansk run—nearly frozen to death in an open boat—both legs lost below the knee—ex-Merchant Marines Michael McCormick and William Morris walked unaided in three weeks. They could look forward with certainty to leading a normal life again. To these men, as to thousands of other Hanger wearers, the phrase "Hanger is a symbol of help and hope" is a concrete truth proven by every day of their future lives.

Hanger
PROSTHESIS

AIR-CONDITIONED OFFICES

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main Street, Evansville, Indiana 47711

mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide.....195 mg.
Aminophylline.....130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



practic manipulations, and are procedures, which in the main, the patient does himself.

Strenuous exercises are not recommended. The author agrees that rest and traction have a place in treatment and presents some sound caution regarding activity and relaxation in our daily living which predisposes us to compression strain and disc dislocations. Maintenance of normal lumbar lordosis by support is recommended while sitting or lying. The measures described are principally prophylactic. The role of surgery and elaborate diagnostic procedures is mentioned but not discussed in detail.

This is a small book, 120 pages, with pen sketches and an ample glossary of orthopedic terms, but no index. Like most writing by English authors, it is clear and concise. There are numerous good diagrammatic sketches illustrating position and exercises.

The book is highly recommended to physicians who treat backache and associated conditions, and to patients with back trouble. It is authoritative and is written from the author's own experience. A preventive and corrective program on how to sit, lie, bend and perform the usual activities of life is clearly presented. Orthopedists will find this book useful to supplement their instructions to patients. This is not a textbook on slipped disc but rather practical advice which has not been previously written for the layman. The format is excellent and the printing is clear (good type). It merits wide distribution to patients.

DAVID A. BICKEL, M.D.
South Bend

PRINCIPLES OF BIOMOLECULAR ORGANIZATION

Ciba Foundation Symposium, edited by G. E. W. Wolstenholme and Maeve O'Connor, Little, Brown & Co., Boston, Mass., 1966; 141 illustrations; 491 pages; \$15.00.

Something like 30 of the world's very distinguished leaders in this most demanding area of biophysics gathered to summarize their separate thinking re our present knowledge concerning the atomical, molecular and crystal structure of organs. Starting with Professor Bernal's opening remarks—I enjoyed his comments anent "heaps" and "piles"(p. 5)—the discussion got into ever deeper waters. The reading is difficult and demands concentrated attention.

The virologists are now able to give us the precise biochemical structures that make up the individual viral particles. The design and functions of fibrous proteins is beginning to make sense. Even the make-up of nerve membrane transmission potentials is ceasing to be an impenetrable mystery.

The average M.D. will not take the effort to plow through this volume. However, it is good to know that we are approaching the day when mystifying speculation will be replaced by certain knowledge. Medical students in the very nearest future will be taught the equations representing "memory", "id", "affect" and many other still esoteric concepts.

The binding and printing are good; typographical errors are conspicuous by their absence. Hospital and medical school libraries are certain to acquire copies for their shelves.

ARNOLD LIEBERMAN, M.D.
New York, New York

Abstracts From Various Literature, Prepared by AMA

PREVENTION OF RHESUS HEMOLYTIC DISEASE

N. P. Walsh, M. C. Path, and Sr. S. Peter (Portiuncula Hosp., Ballinasloe, Ireland)

J. Irish. Med. Assoc. 59:190-193, (Dec.), 1966.

The basic cause of rhesus hemolytic disease is the entry of rhesus positive cells into the circulation of a rhesus negative mother, there stimulating the production of rhesus antibodies which cross the placental barrier and affect the fetal red cell mass. In this study the antibody used was a hyperimmune anti-D- γ -globulin. The globulin was given within 36 hours of delivery and fetal cell counts were carried out 24 hours and 48 hours following injection to ensure that a significant fall in the fetal red cell count had occurred. With the use of pure 7 S γ -globulin, the result was that fetal cells from all the patients to whom it was administered were cleared within 24 hours. No evidence has been shown to date of antibody production in postdelivery samples of blood in any of the treated rhesus negative women.

PSYCHOLOGICAL SEQUELAE OF ACCIDENTAL INJURY: A MEDICOLEGAL QUAGMIRE

A. M. Mann and E. M. Gold (Montreal General Hosp., Montreal)

Canad. Med. Assoc. J. 95:1359-1363, (Dec. 31), 1966.

Litigation for personal injury after accidental trauma is an expensive and confused phenomenon involving three protagonists: patient, doctor, and lawyer. Although posttraumatic conditions can be elaborately classified, their intrinsic validity is often questionable. Current methods of evaluating psychological sequelae of accidental injury are inaccurate and unsatisfactory, partly due to the protagonists' conceptual, motivational, and semantic differences. In addition, there is no really satisfactory method of (a) determining and quantifying minor but significant degrees of brain damage, (b) distinguishing these from posttraumatic neurosis, or (c) determining the relationship between the trauma and subsequent disturbance of function. Expert advice is increasingly solicited, but the nature of the data and conditions of examination do little to clarify the underlying problems. Furthermore, doctors are often unable to communicate effectively to the judiciary how the trauma has affected the patient.

INTELLECTUAL AND PERSONALITY CHANGES FOLLOWING OPEN-HEART SURGERY

H. Gilberstadt and Y. Sako (VA Hosp., Minneapolis)

Arch. Gen. Psychiat. 16:210-214, (Feb.), 1967.

Psychometric intellectual and personality tests before and after open-heart surgery in 53 patients indicated that intellectual loss from brain damage occurred frequently but not to a degree which would significantly impair adjustment in most survivors. Denial was the most frequently used psychological coping mechanism, and normal fear and apprehension were most typical. The incidence of delirium was 13% following surgery which was less than previously reported estimates. It probably resulted because of less bypass time, but it occurred in the most intellectually competent patients, supporting previous hypotheses regarding recovery room sensory deprivation. Patients with the least reserve

removes the mental blur



that clouds vision

SOLFOTON[®]

Each tablet or capsule contains

PHENOBARBITAL.....16 mg.

(Warning: may be habit forming)

BENSULFOID[®] (See P D R).....65 mg.

Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s

Solfoton Capsules (yellow and brown)
100s, 500s, 1000s

Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

due to old age, poor brain endowment, and presurgery neurological complaints are the poorest surgical risks, but many such patients survive.

CAROTID ARTERY SURGERY FOR CEREBROVASCULAR INSUFFICIENCY: EXPERIENCE WITH SEVENTY-EIGHT PROCEDURES IN SIXTY PATIENTS

W. B. Chung (1538 W. 40th Ave., Vancouver, Canada)

Canad. J. Surg. 10:21-27, (Jan.), 1967

Seventy-eight operations were done on 60 patients who had signs and symptoms of cerebrovascular insufficiency and radiological evidence of arteriosclerotic involvement of the extracranial carotid artery. There were 57 partial occlusions and 21 complete occlusions. It was possible to reestablish flow in all the partial occlusions, but only in 6 out of 21 of the complete occlusions. In the 53 patients in whom the flow of one or both carotid arteries was successfully reestablished, 45 (85%) showed clinical improvement after a follow-up of six months to five years. Of the remaining eight patients, two died in the early postoperative period of cerebral infarction, two were unchanged, three got worse, and one died one month after the operation from myocardial infarction. Of the seven patients with unilateral complete occlusions in whom operations were unsuccessful, two showed some improvement, four were unchanged, and one gradually got worse. The overall mortality in 60 patients was three (5%). Improvement of results could be obtained by refinement of technics and more careful selection of patients.

URINARY FINDINGS OF CHILDREN WHO WERE IN UTERO DURING THE ATOMIC BOMBINGS OF HIROSHIMA AND NAGASAKI

L. R. Freedman and R. J. Keeh (Yale Univ. School of Medicine, New Haven, Conn.)

Yale J. Biol. Med. 39:196-206, (Dec.), 1966.

Data from urinalyses at ages nine to 16 were tabulated for children exposed to ionizing radiation in utero at the time of the atomic bombings in Hiroshima and Nagasaki in 1945, and for comparable control groups. Proteinuria was detected more often at various ages in boys in Hiroshima and girls in both cities whose mothers were within 1,500 meters of the bomb hypocenters than in any other distance grouping. The differences were statistically significant in girls at ages 13 and 14. Future investigations will be necessary to define the biological significance of findings.

INHALATION OF OXYGEN AS AN AID TO RECOVERY AFTER EXERTION

R. K. Bjorgum and B. J. Sharkey (Univ. of Montana, Missoula)

Res. Quart. 37:462-467, (Dec.), 1966.

Twelve young men, including six trained endurance runners and six nonrunners, were tested once in each of three treatment situations to determine the effectiveness of oxygen inhalation as an aid to recovery. The exercise test involved two runs of five minutes each on a motor-driven treadmill. The treadmill was set at level grade and a speed of eight mph. After the first run, one of the treatments was administered. The treatments consisted of oxygen, a placebo tank of compressed atmospheric air, and ordinary atmospheric air. Immediately after a one-minute inhalation period, the second five-minute run followed. Heart rates were monitored throughout the testing period, and recovery oxygen

"COCA-COLA" AND "COKE" ARE REGISTERED TRADE-MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY.



consumption and ventilation rate were measured after the second run. The inhalation of oxygen did not appear to be of any physiological aid to recovery. Although not of statistical significance, larger pulse decreases were recorded on the nonrunners during the inhalation of oxygen. Exercise pulse rates indicated that the exercise test elicited near maximal exertion from the nonrunners.

INTRAUTERINE TRANSFUSIONS

V. Halitsky et al. (Queens Hosp. Center, Jamaica, N. Y.)
Amer. J. Dis. Child. 113:245-250, (Feb.), 1967.

A new technic for fetal peritoneal localization is described and the use of a grid for specific point localization of the fetal peritoneal site of injection is advocated. Two patients, in whom in utero transfusion eliminated the necessity of postdelivery exchange transfusions, are presented. Indications for postpartum exchanges in those infants who have had intrauterine transfusion may need revision.

**CHRONIC IRON DEFICIENCY ANEMIA
DUE TO MECKEL'S DIVERTICULUM**

M. Sparberg (USAF Hosp., Lackland Air Force Base, Tex.)
Amer. J. Dis. Child. 113:286-287, (Feb.), 1967.

A six-year-old girl developed chronic iron deficiency anemia without overt rectal bleeding, secondary to a large Meckel's diverticulum. Diagnosis was established preoperatively by roentgenographic demonstration of the diverticulum; resection of the diverticulum resulted in cure. Chronic occult blood loss from a Meckel's diverticulum, rather than gross hemorrhage, is a rare complication. Meckel's diverticulum should be included in the differential diagnosis of iron deficiency anemia associated with chronic occult blood loss from the gastrointestinal tract.

TREATMENT OF EARLY HODGKIN'S DISEASE

P. E. Thompson Hancock (Royal Marsden Hosp., Fulham Rd., London) and E. M. Ledlie
Lancet 1:26-27, (Jan. 7), 1967.

A collaborative study by means of a controlled clinical trial was carried out on a group of patients with early Hodgkin's disease. There is a definite suggestion, so far not statistically significant, that the addition of chemotherapy to radiotherapy of the affected and adjacent regions as part of the initial treatment improves the survival rate.

**THYROID STATUS IN PREGNANCY AND IN
WOMEN TAKING ORAL CONTRACEPTIVES**

A. W. G. Goolden (Radiotherapy Dept., Hammersmith Hosp., Ducane Rd., London), J. M. Gartside, and C. Sanderson
Lancet 1:12-15, (Jan. 7), 1967.

Protein bound iodine and the uptake of ¹³¹I-triiodothyronine by resin were measured in a group of pregnant women, in women taking ethynodiol diacetate and in a control group of healthy volunteers. From these data a free thyroxine factor, which is proportional to the concentration of free thyroxine in the serum, has been calculated. Values for the free thyroxine factor in pregnancy and in women taking ethynodiol diacetate were within the range for euthyroid individuals. These results suggest that thyroid status is normal in women taking estrogen/progestogen compounds. The free thyroxine factor may be used to assess thyroid status in pregnancy and in women taking oral contraceptives.

**SMOKING HABITS OF YOUNGER PATIENTS
WITH MYOCARDIAL INFARCTION**

H. Dorken (I. Med. Univ.-Klinik, Martinistr. 52, Hamburg, Germany)
Munchen Med. Wschr. 109:187-192, (Jan. 27), 1967.

Among the patient material of three clinics in Hamburg, the autopsy material of two pathological institutes, and all deaths in Hamburg in 1956 and 1964, 205 younger men with myocardial infarction at the ages of 19 to 44 years were found. Morphological or other peculiarities are not found in coronary diseases of younger persons (131 autopsies). With two exceptions, there were only smokers who had smoked an average of 25.9 cigarette units daily; mostly they had inhaled (three exceptions). Beginning of smoking was at the age of 19 years. Of the controls (413 healthy persons), 18.4% had never smoked. The daily consumption of the controls was 13.4 cigarette units. This very close correlation between smoking and myocardial infarction in younger men permits the conclusion that tobacco smoke is the essential etiological factor in the origin of this still enigmatical disease.

**THE ASYMPTOMATIC PATIENT
WITH GALLSTONES**

B. P. Colcock (Dept. Surgery, Lahey Clinic Foundation, Boston)
R. B. Killen, and N. G. Leach
Amer. J. Surg. 113:44-48, (Jan.), 1967.

Of 3,112 patients with cholecystitis and cholelithiasis operated upon in an eight-year period, only 134 had no symptoms which could be attributed to the gallbladder. Only 11% (15 of 134 patients) had common duct exploration, and no common duct stones were found. Of the 2,978 symptomatic patients operated upon for gallstones during this same period, the common duct was explored in 28.6% and common duct stones were found in approximately nine percent. This suggests that early surgery in patients with cholelithiasis, when these patients are still asymptomatic, may reduce the incidence of common duct disease. Only one postoperative death occurred in these 134 patients (0.7%).

**DIAGNOSTIC PROBLEMS IN CANCER
OF THE RIGHT COLON**

S. Filipsson and I. Hulten (Kirurgiska Kliniken II, Gothenberg, Sweden)
Nord. Med. 77:52-55, (Jan. 12), 1967.

A recent five-year series of cancer of the right colon was analyzed with respect to symptomatology, diagnostic problems, and the cause of "delays." The most common symptoms were poor general condition, abdominal pain, irregular bowel habits, dyspepsia, and gross melena. Microscopical melena was present in most cases in which the tumor was thus examined. Well over half of the patients had anemia and many had elevated erythrocyte sedimentation rates. The tumor was clinically palpable in nearly half of the cases. At first examination with barium enema the tumor was missed in just over 10% of the cases. Time from the first symptoms to establishment of the diagnosis was just over eight months. In nearly half of the cases there was a considerable "doctor's delay."



DR. BENJAMIN SPECTOR SPEAKER FOR HISTORY OF MEDICINE SOCIETY MEETING

Dr. Benjamin Spector, of the Harvard Medical School, will speak at the September 20 meeting of the John Shaw Billings History of Medicine Society. His topic will be "The History of Medical Codes of Ethics."

The group meets at the I. U. Student Union Building, Indianapolis. The social hour begins at 6:00 p.m., dinner is set for 6:45 p.m. and the speaker at 8 p.m.

Dr. Carlberg in Vietnam

Dr. Dale L. Carlberg, Jeffersonville general practitioner, is currently in Vietnam for a 60-day period of voluntary service. Dr. Carlberg left June 30 and will serve from July 3 to August 31, treating the civilians in that country.

Doctors' Wives Raise \$384,649 To Assist Medical Schools, Students

The Woman's Auxiliary to the American Medical Association this year raised \$384,649.48 for medical schools and medical students, interns and residents.

In presenting the contribution to the AMA Education and Research Foundation, Auxiliary President Mrs. Asher Yaguda, Newark, N. J., noted that the physicians' wives had donated a grand total of \$2,878,432.36 to AMA-ERF since the auxiliary adopted the project in 1951.

The funds given to the nation's medical schools will be unrestricted grants which may be used in any way the school wishes. The money set aside for medical students, interns and residents will guarantee loans to help finance their training.

The Woman's Auxiliary to the Indiana State Medical Association received an award of merit for its outstanding effort in the program in 1966-67.

The Indiana auxiliary made the greatest contribution of any state group in the 2,001-3,000-member category—\$19,124.74. The 1966-67 auxiliary president was Mrs. Alfred B. Scales, Huntingburg. Mrs. Edward M. Johnson, Terre Haute, served as AMA-ERF chairman and Mrs. John W. Deever, Indianapolis, was president-elect.

The Woman's Auxiliary to the Vanderburgh-Southwestern, Indiana, Medical Society also received a special achievement award for its outstanding efforts.

With a membership of 193, the Vanderburgh-Southwestern auxiliary raised \$3,511.37 for AMA-ERF. Total national contribution was \$384,649.48, part of which will be given to medical schools for unrestricted use. The remainder will go to the student loan guarantee fund, which makes possible long-term bank loans to medical students, interns and residents, with no payment due on either interest or principal until five months after completion of all training. AMA-ERF acts as the guarantor.

The 1966-67 Vanderburgh-Southwestern president was Mrs. Robert Beck; AMA-ERF chairman was Mrs. Clyde Burrell. Both are from Evansville.

Dr. Stoelting Program Director

Dr. Virgil K. Stoelting will be the Training Program Director at Indiana University Medical Center for special training in anesthesiology to be provided by a grant of \$14,606 from the U. S. Public Health Service. This is a part of a \$1 million grant program involving 30 teaching hospitals in an effort to support training in anesthesiology.

Parkview Hospital Assistant Administrator Graduates Course

Mr. Eugene M. Secrist, Assistant Administrator, Parkview Hospital, Plymouth was graduated recently from a Health Services Administrators Development Program conducted by the University of Alabama. Fifteen hospital administrators from eight states were enrolled.

The course started with a two-weeks in-residence session in Birmingham last summer, was conducted by correspondence for nine months and was concluded by a two-weeks program this spring.

Dr. Martz Elected

Dr. Bill L. Martz, Brownsburg, was elected a vice-president of the American College of Cardiology at a recent meeting in Washington, D.C.

Dr. Buchanan Appointed Chairman Of "Independent Billing" Committee

Dr. Wallace Buchanan, South Bend, has been appointed the chairman of the "Committee on Private Practice and Independent Billing" of the American College of Radiology. Dr. Buchanan is a past-president and former board chairman of the college.

His committee will educate and assist members as to the desirability of practicing under fee-for-service arrangements, both in private offices and in hospitals. Indiana is one of several states considered by the college to have the best records on separate billing.

Dr. Moore on Panel

Dr. Thomas C. Moore, formerly of Muncie, was a member of a panel discussion on pediatric surgery at a recent sectional meeting of the American College of Surgeons in New York City. Dr. Moore is currently practicing in Richmond, Va.

Public Health Service Reprints Booklet Listing Available Films

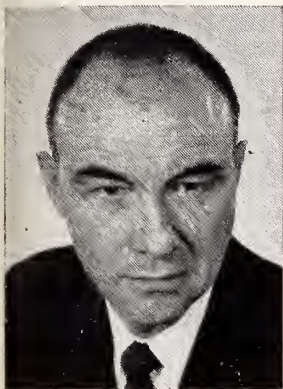
The Public Health Service has reprinted a 58-page booklet which lists selected films dealing with heart disease, cancer and stroke, with full information on the distributing agents.

For copies of the booklet write Communicable Disease Center, Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Dr. Christensen Named Director of Lilly Research Planning Division

Charles N. Christensen, M.D., has been promoted by Eli Lilly and Company to director of the medical research planning division.

A native of South Dakota, Dr. Christensen was graduated from high school in Waubay in 1939. He attended Huron College and in 1943 received a Bachelor of Science degree in medical science, *summa cum laude*, from the University of South Dakota School of Medicine. In 1945 he received his Doctor of Medicine degree from the University of Pennsylvania School of Medicine and then served a one-year internship and a two-year residency in pediatrics at the hospital of the University of Pennsylvania.



From 1950 to 1955 Dr. Christensen was in private practice in Springfield, Illinois. He then became chief of pediatrics at Miner's Memorial Hospital in Pikeville, Kentucky, and served there from 1955 until he joined Eli Lilly and Company in 1957. As a physician in the medical division, he was responsible for handling correspondence with physicians concerning vitamin products and biologicals.

In 1963 Dr. Christensen was promoted to an assistant director in the medical administration division and in 1966 became an assistant director in the clinical research division. He is currently on the pediatric staff at Marion County General Hospital.

A Fellow of the American Academy of Pediatrics and the American Board of Pediatrics, Dr. Christensen is a member of the American Association for the Advancement of Science; the Indiana Pediatric Association; and Phi Rho Sigma, professional medical fraternity. Formerly secretary of the medical section of the Pharmaceutical Manufacturers Association, he is now serving as chairman of its subcommittee responsible for liaison with the American Medical Association.

Dr. Sweeney Named Chairman

Dr. Robert M. Sweeney, South Bend, has been named chairman of the newly formed Cystic Fibrosis Committee for St. Joseph County.

Purdue University Recipient of U.S. Public Health Service Award

Purdue University is the recipient of an award by the U. S. Public Health Service of \$682,002 for the expansion of spectrometric facilities to the status of a center designed to serve the regional scientific community through a broad program of research.

The advanced and sophisticated tools made possible by this development will be useful in determining the molecular structure of biological materials.

Dr. Earp Named to Health Post

Dr. Evanston B. Earp, Indianapolis, has been named assistant director of the Marion County Division of Public Health.

E. Mead Johnson Awards Go to Three Out-of-State Physicians

E. Mead Johnson Awards have been announced by the American Academy of Pediatrics to be presented at their annual meeting in October.

Drs. Harry M. Meyer, Jr. and Paul D. Parkman of Bethesda, Maryland received one award jointly for their contributions in developing a test for detecting immunity to rubella. Dr. Henry Neil Kirkman, Chapel Hill, North Carolina received the other award for his studies of glucose-6-phosphate dehydrogenase deficiency. Each award consists of \$3,000, a scroll and a certificate.

Dr. Irwin is Speaker

Dr. Glenn W. Irwin, Jr., Indianapolis, was speaker at a recent meeting of the alumni of Manchester College. His topic was "Medical Education in Indiana."

"Challenge of Obstetric Anesthesia" to be Subject of Fiske Fund Prize Dissertation

The Trustees of the Fiske Fund of The Rhode Island Medical Society announce the following subject for the Prize Dissertation of 1967: "The Challenge of Obstetric Anesthesia."

For the best dissertation on the subject worthy of a premium they offer the sum of five hundred dollars (\$500.00). The dissertation will be particularly graded on the basis of original work by the author. Each competitor for the premium is expected to conform with the following regulations:

To forward to the secretary of the trustees on or before the eleventh day of December, 1967, free of all expense, a copy of his dissertation with a motto thereon, and also accompanying it a sealed envelope bearing the same motto inscribed on the outside, with his name and address within.

Previous to receiving the premium awarded, the author of the successful dissertation must transfer to the trustees all his right, title and interest in and to the same, for the use, benefit, and advantage of the Fiske Fund.

Dissertations, other than the successful one, will be returned

OCCUPATIONAL MEDICINE

Chrysler Corporation is offering challenging executive level opportunities in Detroit with exciting growth company to physicians who have a career interest in Occupational Medicine.

Excellent remuneration and executive benefits.

Please write: M. F. Bruton, M.D., Director, Medical Services, Chrysler Corporation, P.O. Box 1919, Detroit, Michigan—48231, or call collect Area code 313 - 883-4500, Extension 2975 for complete information and appointment.



An Equal Opportunity Employer

to the authors. The dissertations must be typewritten, double spaced on standard typewriter paper and should not exceed 10,000 words. All correspondence should be directed to: Secretary John E. Farrell, Sc.D., 106 Francis St., Providence, Rhode Island 02903.

Dr. Stucky Heads Staff

Dr. Jerry L. Stucky, Fort Wayne, heads the Parkview Hospital medical staff for 1967.

Dr. Jansen Named a Senior Physician at Eli Lilly & Company



Dr. C. J. Jansen, Jr., has been named a senior physician in the medical research division of Eli Lilly and Company. He serves as monitor for the medical aspects of the Lilly cancer research program.

A native of Ft. Thomas, Kentucky, Dr. Jansen received a Bachelor of Science degree *cum laude* from Xavier University in 1950. St. Louis University School of Medicine awarded his Doctor of Medicine degree in 1954.

Dr. Jansen served a rotating internship at Good Samaritan Hospital in Cincinnati, Ohio, completed a residency in internal medicine at the Veterans Administration Hospital in Louisville, Kentucky, and from 1958 to 1961 was an instructor in medicine at the University of Louisville School of Medicine. He joined Eli Lilly and Company in 1961.

SCIENTIFIC SHOE FITTING

Since shoes are the foundation for the entire body they deserve scientific fitting as to the person's size, last and foot shape.

If abnormalities exist we apply arches, metatarsal bars, wedges, Thomas heels and the necessary shoemaking alteration to encourage helpful function of the foot and limbs. Only then can the shoe enable proper stance, posture and walking satisfaction for man, woman, child.

This service is assured by experienced shoe fitters and trained Orthopedic shoemakers. Both must work together to get the best results. A pharmacist compounds a prescription so should a professional shoe fitter make applications for shoe corrections.

Heid's follow up service during the life of the shoe is also of utmost importance since the response may differ with each individual. Often a slight alteration makes for lasting comfort and satisfaction.

This scientific shoe fitting and corrective application is a service offered by Heidenreich and Son who operate the Heid's Health Shoe Store at 411 N. Illinois St., Indianapolis, Indiana.

Your referrals and prescriptions will receive accurate, conscientious attention at reasonable, ethical charges. No job too big, none too small.

Dr. Woolling Presents Paper

Dr. Kenneth R. Woolling, Indianapolis, presented a paper entitled "Venous Gangrene" at the recent scientific session of the North Central Clinical Society, at Cleveland, Ohio.

Health Insurance Institute Offers Educational Materials Booklet

The Health Insurance Institute has published a booklet "Health Education Materials—and the organizations which offer them."

The national organizations listed offer either free or inexpensive informational and educational materials, with those offering free literature to students specifically identified. The listed materials are broken down by topics. Write Department H, Health Insurance Institute, 277 Park Ave., New York City 10017.

Dr. Segar is Speaker

Dr. William E. Segar, Indianapolis, spoke on "Common Kidney Problems" at a recent seminar in the Methodist Hospital Graduate Medical Center.

Child Health Care Standards Manual now Available to Physicians

A manual on child health care standards is available from the American Academy of Pediatrics.

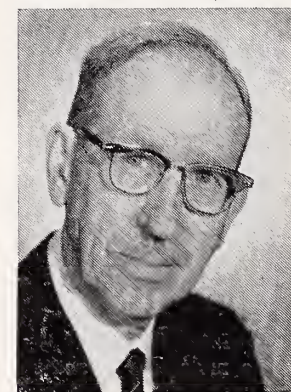
"Standards of Child Health Care" is intended not only to serve as a guide for practicing pediatricians, especially those now in training, but also seeks to assist those who will plan or administer future child health programs. The manual may be obtained from the Academy at \$2.00 per copy.

Dr. Gambill is Speaker

Dr. J. R. Gambill, Indianapolis, spoke on "Ways of Preventing Mental Disability" at a recent meeting of the Wayne-Union County Medical Society held at the Richmond State Hospital.

Dr. Don Carlos Hines Retires From Eli Lilly & Company

Don Carlos Hines, M.D., director of the medical special services division of Eli Lilly and Company, has retired from the company.



Dr. Hines joined Eli Lilly and Company in 1939 as a physician in the medical department and became head of that department in 1951. In 1953 he was promoted to director of the medical research division and was named director of the medical special services division in 1965.

The work of the Lilly Research Laboratories has included the initiation and monitoring of clinical investigations and the supervision of others who perform clinical studies.

Special attention is paid to the toxicity and side-effects of drugs. The role of the medical special services division under Dr. Hine's direction has been to provide leadership and staff support in the planning of clinical investigations and the handling of data derived from them.

Since 1939 Dr. Hines has been a member of the courtesy staff of the Marion County General Hospital. He was secretary of the board of directors of Park School (Indianapolis) for a number of years and is a member of its Foundation.

Dr. Hines and his wife, Anne, will move to 2525 Larkin Street San Francisco.

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING

Date November 26-29, 1967
Place Houston, Texas

INDIANA STATE NURSES ASSOCIATION

Date Oct. 12-14, 1967
Place French Lick-Sheraton Hotel,
French Lick

INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 9-12, 1967
Place Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every month,
September through June
Place For location and program, inquire
Beatty Memorial Hospital, Westville

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER

Date May 17-18, 1968
Place Stouffer Inn, Indianapolis

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.

Date December 2, 1967
Place Indianapolis Motor Speedway
Motel, Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION

Date Second Wednesday of the month,
October through May, excluding
December
Place The Athenaeum, Indianapolis

BONE AND JOINT CLUB

Date October 18, 1967
Place Athenaeum, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Date January 10, 1968
Place Stouffer Inn, Indianapolis

INDIANA ROENTGEN SOCIETY

Date October 10, 1967
Place Murat Theater, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE

Date March 26-28, 1968
Place Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS

Date May 25-26, 1968
Place Marott Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION

Date Nov. 1-3, 1967
Place French Lick-Sheraton Hotel,
French Lick

INDIANA ACADEMY OF OPHTHAL- MOLOGY AND OTOLARYNGOLOGY

Date May 1-2, 1968
Place Culver Inn, Culver

INDIANA STATE DENTAL ASSOCIATION

Date May 19-20, 1968
Place Murat Theater, Indianapolis



when he just can't sleep
Tuinal[®]

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, $1\frac{1}{2}$, and 3-grain Pulvules[®]**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—June, 1967

Disease	June 1967	May 1967	April 1967	June 1966	June 1965
Animal Bites	1626	955	1055	1476	1575
Chickenpox	117	274	341	196	304
Conjunctivitis	61	81	109	131	156
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	9	21	34	37	53
Gonorrhea	445	371	303	497	443
Impetigo	75	54	92	86	143
Infectious Hepatitis	36	52	75	28	52
Infectious Mononucleosis	34	64	84	48	40
Influenza	50	277	1050	360	199
Measles (Rubeola-Rubella)	122	216	257	1241	629
Meningitis, Meningococcal	1	6	5	8	7
Meningitis, Other	1	5	2	6	6
Mumps	509	665	1008	309	324
Pertussis (whooping cough)	22	20	21	5	13
Pneumonia	204	143	333	419	182
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	277	417	744	513	437
Syphilis					
Primary & Secondary	16	9	8	9	7
All Other Syphilis	231	100	87	119	92
Tinea Capitis	10	2	9	4	14
Tuberculosis (Active)	113	77	96	102	125

*When the problem
is only skin deep*

USE 'POLYSPORIN'[®] brand POLYMYXIN B-BACITRACIN OINTMENT

**for topical antibiotic therapy with minimum
risk of sensitization**

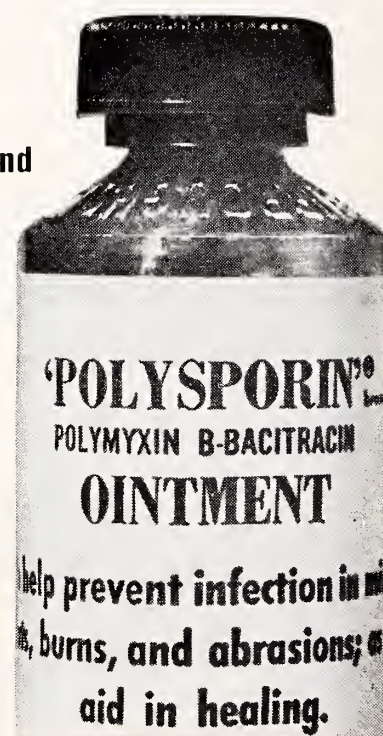
Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in 1/2 oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



FUTURE MEETINGS, SEMINARS, COURSES

27th Congress on Occupational Health Will be September 25-26

The 27th Congress on Occupational Health will be held at the Regency Hyatt House, Atlanta, Georgia, on September 25 and 26.

Room reservations may be made directly with the hotel. The program is credited for 11 elective hours by the American Academy of General Practice.

Symposium on Acute Leukemia And Burkitt's Tumor Announced

A Symposium on Acute Leukemia and Burkitt's Tumor will be held at the Boston Museum of Science in Boston, Massachusetts September 20. This symposium is being sponsored by the American Cancer Society and the National Cancer Institute.

The meeting is open to all members of the medical profession and students. There is no advance registration or fee.

For further information, write: Dr. Jack W. Milder, Research Department, American Cancer Society, Inc., 219 E. 42 St., New York, New York 10017.

November Postgraduate Course In Laryngology, Bronchoesophagology

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology from November 6 through 17, 1967.

This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, M.D. It will be held largely at the new Illinois Eye and Ear Infirmary, 1855 W. Taylor St., Chicago, and will include visits to a number of Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Ill. 60680.

1967 Wells County Fall Clinical Conference to be Held September 21

The 1967 Wells County Fall Clinical Conference will be held September 21st at the Dutch Mill in Bluffton at 6:30 p.m.

Dr. David Klein, professor of ophthalmology at the University of Geneva, Switzerland, will talk on genetic eye diseases. This conference has been certified for two hours credit by the Indiana Academy of General Practice. Mail reservations to Dr. D. W. Meier, Bluffton, Ind.

"Basic and Clinical Aspects of Therapy in Advanced Cancer" Course

A course on the "Basic and Clinical Aspects of Therapy in Advanced Cancer" will be conducted at the University of Wisconsin Medical Center on October 16 to 21.

The purpose of the course is to demonstrate the practical clinical application of laboratory science discoveries in anti-cancer therapy. For further information write Dr. R. J. Samp, University Hospitals, Madison, Wisconsin, 53706.

Gastroenterology Postgraduate Course Listed for November 2-4

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology at the Biltmore Hotel, Los Angeles, on November 2, 3, and 4.

The subject matter will cover recent advances in both the medical and surgical fields. For further information and enrollment write to the College at 33 W. 60th St., New York City 10023.

The Society for Cryo-Ophthalmology Announces Second Annual Meeting

The second annual meeting of the Society for Cryo-Ophthalmology will be held in Miami Beach, January 14 to 18, 1968, with Dr. Jose Barraquer, of Bogota, Colombia, presiding. The program will include a session on retinal surgery, with Dr. Giambattista, of Rome, as the featured speaker. Dr. H. Fanta, of Vienna, will lead the discussion on cryoextraction of cataracts.

Those wishing to present papers at this meeting should submit title and brief abstract to Dr. John G. Bellows, executive secretary, 30 N. Michigan Ave., Chicago, Illinois 60602, at the earliest possible date.

Annual Otolaryngologic Assembly Scheduled for October 14 through 20

The Annual Otolaryngologic Assembly of 1967 will be held October 14 through 20 in the new Illinois Eye and Ear Infirmary at the Medical Center, Chicago. The Department of Otolaryngology of the College of Medicine of the University of Illinois offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Dr. Emanuel M. Skolnik. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

A separate, but correlated course entitled "Head and Neck Radiology Conference" will be conducted by the Department of Radiology for two full days just preceding the Assembly on Thursday and Friday, October 12 & 13. Interested physicians should direct communications to the mailing address: Department of Otolaryngology, P. O. Box 6998, Chicago, Illinois 60680. ◀

County, District News

Second District

The Second District Medical Society met June 8 and elected Dr. Betty Dukes, Dugger, as its alternate councilor. Speakers at the annual meeting included Dr. Charles W. Wunsch on "Coronary Heart Disease" and Dr. Charles Risch on "Coronary Care Units." Both of the doctors are from Indianapolis.

Fourth District

Newly-elected president of the Fourth District Medical Society is Dr. Frank Bard, of Crothersville. Assisting him will be Dr. Bill Freeland, Batesville, vice-president and Dr. Harold Miller, Seymour, secretary. Dr. Jack Shields, Brownstown, was elected alternate councilor.

Fayette-Franklin

Field Secretary Robert Amick met June 13 with the Fayette-Franklin County Medical Society at Brookville. Nine members attended.

Jackson-Jennings

New officers of the Jackson-Jennings County Medical Society are: Drs. Kenneth E. Bobb, Seymour, president and William F. Blaisdell, Seymour, secretary-treasurer. Delegates will be Drs. Harry Baxter and Forrest D. Ellis; alternates will be Drs. William Scharbrough and William A. Johnson.

Knox

The Knox County Medical Society has elected the following as its new officers: Drs. Boyd Black, president; Charles L. Miller, president-elect; John Murray, sec-

retary; Ralph Jacqmain, treasurer and Herbert O. Chattin, delegate.

Parke-Vermillion

Dr. John Somerville, Clinton, has been elected president of the Parke-Vermillion County Medical Society and Dr. Milton Herzberg, Clinton, secretary-treasurer.

Vanderburgh

Officers of the Vanderburgh County Medical Society for 1967-68 will be: Drs. Eugene W. Austin, president; Ralph F. Carlson, president-elect; R. Case Hammond, vice-president and Paul E. Streuh, treasurer.

Wabash

Dr. H. H. Dunham, Wabash, is the current president of the Wabash County Medical Society. ◀

Deaths

Clifford F. Bussard, M.D.

Dr. Clifford F. Bussard, 81, practicing physician in South Bend for over 50 years, died July 6 after a short illness.

Graduated from the St. Louis University School of Medicine in 1913, Dr. Bussard lived in South Bend from 1914 until his death. He was a member of the St. Joseph County Medical Society, a Senior Member of ISMA and a member of the 50-Year Club.

Gordon A. Dickerson, M.D.

Dr. Gordon A. Dickerson, a practicing physician in Petersburg several years, died June 2. He was 67.

Dr. Dickerson, a former member of the Pike County Medical Society, was graduated from the I.U. School of Medicine and served in World War II.

Bernard A. Kamm, M.D.

Dr. Bernard A. Kamm, South Bend physician, died July 7 in St. Joseph's Hospital there at the age of 68.

An ear, nose and throat specialist, Dr. Kamm had been active in practice until

he became ill the latter part of June. He was graduated from the St. Louis University School of Medicine in 1925, was associated with the Barnes Clinic there and took his residency at St. Louis City Hospital. He was a member of the St. Joseph County Medical Society.

Charles Y. Knowles, M.D.

Robert P. Knowles, M.D.

Dr. Charles Y. Knowles, 46, and Dr. Robert P. Knowles, 44, Indianapolis physicians and brothers, were both killed June 21 when a private plane in which they were riding crashed.

Dr. Charles Knowles, a pediatrician, was graduated from the I.U. School of Medicine in 1944. He was on the staffs of the Community and I.U. Medical Center Hospitals.

Dr. Robert Knowles was an obstetrician and gynecologist and was graduated from Indiana University in 1945. He was on the staffs of the Methodist, Community, St. Vincent's, General and I.U. Medical Center Hospitals. Both physicians were members of the Marion County Medical Society.

Lon S. Taylor, M.D.

Dr. Lon S. Taylor, retired physician and former member of the Warrick County Medical Society, died June 14 in Evansville.

Graduated from the University of Louisville School of Medicine in 1908, Dr. Taylor practiced medicine in Stanley and Elberfeld. He retired in 1958 and moved to Vanderburgh county.

John H. Warvel, Sr., M.D.

Dr. John H. Warvel, Sr., one of the nation's leading physicians in the treatment of diabetes, died June 19 at his home. He was 73.

Dr. Warvel became one of the first physicians to use insulin in the treatment of diabetes, shortly after its discovery in 1922. He was a consultant to Eli Lilly & Co. on the use of insulin for diabetes and was one of the founders of the Indianapolis Diabetes Association and its first president.

Graduated from Ohio State University School of Medicine in 1916, Dr. Warvel had lived in Indianapolis since 1919. He was on the staffs of the Methodist, St. Vincent's, Community and General Hospitals; was a Senior Member of ISMA, member of the 50-Year Club and the Marion County Medical Society. ◀

Association News

EXECUTIVE COMMITTEE

June 10, 1967

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D.; Lowell H. Steen, M.D.; Ottis N. Olvey, M.D.; Lester H. Hoyt, M.D.

Robert Robinson, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of	
December 31, 1966	4,409
1967 members as of May 31, 1967:	
Full dues paying	3,818
Residents and interns	97
Council remitted	46
Senior	307
Honorary	3
Military	41
Total 1967 members as of	
May 31, 1967	4,312
Number of members as of	
May 31, 1966	4,329
Loss over last year	18

Number of AMA members as of	
May 31, 1967	4,140
Total 1966 AMA members as of	
May 31, 1966	4,212
Loss over last year	72
1967 AMA members:	
Dues paying	3,646
Exempt, but active	494
	4,140
Number who have paid state	
dues but not AMA dues as of	
May 31, 1967	172

Headquarters Office

By consent, the treasurer was authorized to sign retirement certificates.

The committee interviewed potential employees, Mr. Paul Pierce and Mr. Robert Robinson.

The secretary reported on his visit to OCHAMPUS headquarters in Denver.

Treasurer's Office

The treasurer's report for the months of April and May and the statement of cash fund balances were accepted by consent.

On motion of Drs. Steen and Hoyt, the treasurer was authorized to apply \$7,500.00 toward the indebtedness of the Pennsylvania Street properties.

Building Matters

A letter from the Woman's Auxiliary, enclosing a contribution of \$1,200.00 to the Kitchen Fund of the association, was noted, and on motion duly made and seconded, a letter of appreciation is to be forwarded to the auxiliary for its generous contribution.

Organization Matters

A letter from Donald E. Rhamey, M.D., was reviewed for the information of the committee.

A letter from Richard M. Johnston, M.D., was reviewed for the information of the committee, and the president stated that he had requested Dr. Johnston to discuss this matter with the councilor of his district.

A letter from Mr. C. William Johnson, convention chairman of the Indiana University Chapter of the Student American Medical Association, expressing the appreciation of the Indiana organization for the assistance of the association in helping finance the recent Regional IV convention of the Student American Medical Association and reporting on the meeting was reviewed for the information of the committee.

A letter from Allan C. Erickson, Program Director, American Cancer Society, Indiana Division, addressed to the president of the association, seeking the association's support in the campaign against smoking, was reviewed and by consent the endorsement of the association is to be given to this program.

A proposal which had been sent out from the American Association of Medical Assistants regarding changes in its constitution and bylaws was reviewed and by consent the secretary was instructed to file a protest with the Indiana Medical Assistants Association concerning the proposed change in Section 3 of the bylaws of the national organization.

A letter from the Bureau of Protective Analysis, together with a legal opinion concerning this operation, was reviewed for the information of the committee and by consent this material is to be forwarded to the State Board of Medical Registration and Examination.

The request of the Commission on Special Activities for an appropriation for the orientation program was brought before the committee and by consent it was agreed to table any action on this request until after the meeting of the House of Delegates in October.

A letter from Dr. Neumann concerning the recent activities of the Blue Cross and Blue Shield Board was brought to the attention of the committee and by consent it was agreed to refer this matter to the Council Liaison Committee with Blue Shield.

A letter from the Wabash County Medical Society was reviewed for the information of the committee.

A letter from the president-elect of the AMA concerning a proposed letter to be addressed to all physicians in the country

was reviewed and the president of the association will discuss this with the AMA president-elect during the Atlantic City meeting.

Communication from the American Medical Association Department of Investigation concerning an Indiana chiropractor was reviewed and by consent it was agreed that this information should be forwarded to the State Board of Medical Registration and Examination.

A letter from Mr. Albert Kelly thanking the association for its action in setting a cut-off date for filing of claims for services provided welfare recipients over 65 under PL 89-97 and enclosing a copy of the official action taken by the State Welfare Board, was read for the information of the committee.

A letter from Mutual of Omaha concerning its Code-a-Phone System was reviewed for the information of the committee.

A letter from Dr. Joseph G. S. Weber of Terre Haute concerning the advertisement of an insurance company was reviewed for the information of the committee as well as comments from the state and county medical societies in which the insurance company is domiciled.

Correspondence between Dr. P. J. V. Corcoran and others was reviewed for the information of the committee.

A copy of a letter from the American Medical Association, addressed to the governor of the state of Indiana, recommending the lodging of the responsibility for implementing the new traffic safety regulations, known as PL 89-564, in the State Board of Health was reviewed for the information of the committee.

A letter from the American College of Surgeons concerning "Standards for Emergency Ambulance Services" was referred to the Council Committee on Emergency Medical Services, upon motion of Dr. Steen, taken by consent.

A letter from the Delaware-Blackford County Medical Society concerning area-wide planning, addressed to the local community, was reviewed for the information of the committee.

A letter from the American Medical Association, addressed to Sheldon S. Cohen, Commissioner of Internal Revenue Service, objecting to the proposed regulations concerning unrelated income, was reviewed for the information of the committee.

An excerpt from the minutes of the Blue Cross Board meeting concerning a communication from Walter P. Reuther, president of the United Automobile International Union, containing a copy of a statement adopted by the Executive Board of the UAW with respect to national uniform health care benefits, was read for the information of the committee.

A letter from AMDOC, Inc., seeking help of the association in obtaining physicians for overseas employment was authorized to be published in *The Journal*.

Annual Convention, Indianapolis, October 9, 10, 11 and 12, 1967

An outline of the annual convention schedule was reviewed and upon motion of Dr. Steen, taken by consent, the Executive Committee is to recommend to the Council that the resolution passed by the House of Delegates in 1963 which requires reference committee reports to be available to delegates 24 hours in advance of the final meeting of the House be amended to provide that reports be completed 12 hours prior to the final meeting rather than 24 hours, in order to give staff time to prepare this material for distribution.

AMA Meeting

Arrangements for the Atlantic City meeting of the American Medical Association were reviewed by the secretary, and the secretary also reviewed the recent actions of the AMA Board of Trustees.

The schedule of events of the Atlantic City meeting, together with letters from the Nevada, Florida, New Mexico, Pennsylvania, Missouri and Louisiana State Medical Associations were referred to the Council meeting with the AMA delegates.

A letter from the American Medical

Association, addressed to the secretary and commenting on the fact that no change had been made in policy statement D-5150 in the Public Assistance Handbook concerning the dispensing of drugs by physicians, was reviewed for the information of the committee, and the secretary was instructed to draft a resolution for submission to the Council meeting with the AMA delegates on June 11, to be introduced by the delegates at the Atlantic City meeting.

An excerpt from the minutes of the Veterans Liaison Committee in which a representative of the Indiana Pharmaceutical Association was reported to have commented that the pharmacists had requested the governor to veto the bill to implement Title XIX in Indiana because the bill did not contain the provision that physicians could dispense drugs only when adequate pharmacy facilities are not available, was read for the information of the committee.

New Business

The chairman of the Council raised the question about the convention in Fort Wayne and recommended that some of the officers, along with the executive secretary, sometime this summer make a careful review of the facilities in Fort Wayne.

Medical Defense

A letter from Hollowell and Robinson,

submitting their statement for services for the first quarter of 1967 was approved for payment on motion of Drs. Steen and Rifner.

The request of the Blackford County Hospital staff for the executive secretary and the legal counsel of the association to meet with the staff in July was approved by consent.

Future Meetings

An invitation for the association to name a representative to the 45th Annual Session of the American Congress of Rehabilitation Medicine, to be held on August 27 to September 1, 1967, in Miami Beach was reviewed, and no representative will be sent.

An invitation for a representative to attend a meeting of the AMA Committee on Nursing, to be held in Chicago, October 6, 1967, was reviewed and by consent Dr. Steen agreed to represent the association at this meeting.

An invitation to send a representative to the 11th National Conference of Schools and Physicians in Chicago on October 4-7, 1967, was reviewed and by consent Dr. Donald Kerr is to represent the association at this meeting.

There being no further business the committee adjourned, to meet again at 2:00 p.m., Saturday, July 29, 1967. ◀

THE COUNCIL

June 11, 1967

A special meeting of the Council with the delegates and alternate delegates to the American Medical Association was called to order by the chairman, Dr. Lowell H. Steen, at 10:00 a.m., Sunday, June 11, 1967, in the headquarters office of the Indiana State Medical Association, 3935 North Meridian Street, Indianapolis.

Roll call showed the following present:

Councilors:

Second District—Joe Dukes, Dugger
Betty Dukes, Dugger, alternate
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Fifth District—Wilbert McIntosh, Riley
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Eleventh District—Lowell J. Hillis, Logansport
James A. Harshman, Kokomo, alternate

Twelfth District—Milton F. Popp, Fort Wayne

Thirteenth District—Otis R. Bowen, Bremen

George B. Gattman, Elkhart, alternate

Officers:

Eugene S. Rifner, Van Buren, president
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

Executive Committee:

Ralph V. Everly, Indianapolis, chairman

AMA Delegates:

Harold C. Ochsner, Indianapolis
Eugene F. Senseny, Fort Wayne
Guy A. Owsley, Hartford City

AMA Alternate Delegates:

James H. Gosman, Indianapolis
Robert M. Brown, Marion
Kenneth O. Neumann, Lafayette

AMA Trustee:

Lester D. Bibler, Indianapolis

The following were absent:

Councilors:

First District—P. J. V. Corcoran, Evansville

Alternate Councilors:

First District—Gilbert M. Wilhelmus, Evansville
Third District—E. L. Wallace, New Albany
Fourth District—Jack E. Shields, Brownstown (also AMA delegate)
Fifth District—A. W. Cavins, Terre Haute
Sixth District—Frank H. Green, Rushville (also AMA delegate)
Seventh District—John O. Butler, Indianapolis
Eighth District—Paul W. Sparks, Winchester
Ninth District—Clarence G. Kern, Lebanon
Tenth District—Herman Wing, Gary
Twelfth District—William R. Clark, Fort Wayne

Officers:

G. O. Larson, LaPorte, president-elect

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Burton E. Kintner, Elkhart, member

AMA Delegates:

Frank H. Green, Rushville (excused)

Jack E. Shields, Brownstown

AMA Alternate Delegates:

Maurice E. Glock, Fort Wayne

Dwight W. Schuster, Indianapolis

The following members of the ISMA staff were present:

Robert J. Amick, field secretary

Robert Robinson, attorney

Kenneth W. Bush, administrative assistant

J. A. Waggener, executive secretary

The chairman welcomed the new alternate councilor from the Second District, Dr. Betty Dukes, Dugger, and commented that this is the first time a woman physician has been a member of the Council.

Dr. George B. Gattman of Elkhart, also was welcomed as the new alternate councilor of the Thirteenth District, succeeding Dr. Robert L. Rouen, Elkhart.

Minutes of the April 9, 1967, Council meeting were approved on motion of Drs. Taylor and Dukes.

Reports of Council Liaison and Special Committees of the Council

Blue Shield: Dr. Kerr reported on a meeting held June 10, 1967, between the Council Liaison Committee with Blue Shield and officials of the Blue Shield Executive Committee concerning several matters which had been called to the attention of the association with respect to the operation of the Blue Shield Plan.

Also, the chairman reported on the presentation made by the president of the association to Blue Shield calling upon them to immediately undertake an intensive study of a plan whereby they might provide a prepayment program for complete health care coverage.

Blue Cross: Dr. Neumann reported on the recent action of the Blue Cross Board in which Blue Cross had proposed to permit payment for pathological and radiological services rendered on an outpatient basis rather than requiring the patient to be admitted to the hospital before surgical schedules could be arranged, which many times necessitated the patient to be hospitalized from three to five days for work-up and surgery. It was felt that by doing this the patient could be admitted the night before surgery, thus reducing the cost of an extended hospital stay. Following discussion, **on motion of Drs. Taylor and Popp, the matter was referred to the Council Liaison Committee with Blue Cross.**

Matters Referred to Council by Executive Committee

a. **AMA Field Service:** The chairman of the Executive Committee discussed the feelings of the Executive Committee concerning the field service of the AMA, and it was felt that the committee should meet with the officers of the American Medical Association to obtain a change in this representation, and if unsuccessful, perhaps a resolution should be introduced to bring about such a change.

b. **Department in Research and Planning:** The chairman of the Executive Committee reviewed with the Council the idea of a new Department in Research and Planning of ISMA, dealing with areawide planning, comprehensive health planning, traffic safety, heart disease, cancer and stroke and the possibility of the employment of a person to direct this department. He stated that the members of the committee had interviewed a Mr. Paul Pierce and a Mr. Robert Robinson as prospective employees and that they had instructed the executive secretary to proceed with the employment of Mr. Robert Robinson for this activity. **Upon motion of Drs. Popp and Petrich, the action of the Executive Committee was approved.**

c. **Resolution for presentation to AMA:** The following resolution on the policy for dispensing drugs under Title XIX, as proposed by the Executive Committee, was presented to the Council, and **on motion of Drs. Kerr and Popp, the AMA delegates were instructed to introduce this resolution at the Atlantic City meeting of the AMA:**

RESOLUTION

Introduced by: Indiana Delegation

Subject: Drug Dispensing Provisions Title XIX

Whereas, In the Handbook of Public Assistance Administration, Supplement D, dealing with Medical Assistance Programs under Title XIX of the Social Security Act; and

Whereas, A policy statement referred to as D 5150 reads as follows:

"Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the definitions, items 1 through 15, in D 5141 (also see D 5800).

"DRUGS—with respect to 'prescribed drugs' as defined in D 5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists, and, when dis-

persed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof."

Whereas, this policy statement is to be proposed as a regulation; and

Whereas, this tends to delimit the right of the physician to dispense drugs, increases his paperwork and leaves an avenue open for argument as to who will define "where no adequate pharmacy services exist or are available when needed"; therefore be it

Resolved, That the American Medical Association voice its strenuous objection to the policy as enunciated in the Handbook and seek its removal as a policy for dispensing drugs under Title XIX.

d. **Remarks of the President:** The president of the association reported on his activities and commented on his proposal to the Blue Shield Board, **and the recommendation of the president to Blue Shield was approved by consent and the secretary was instructed to distribute copies of this communication to the members of the Council and to include it in toto in the minutes of the Council.**

Dr. Rifner's statement follows:

In the recent meeting of the Annual Blue Shield Conference in April it was pointed out to us that management expects certain comprehensive health packages and that such packages would be provided for hourly employees.

My proposal is that the Blue Shield Board and the Blue Shield Liaison Committee sit down and write out a comprehensive care program that would be acceptable to the medical profession and fulfill the needs of industry. I would request that this be done so it could be sold in packages—each one more comprehensive than the prior one. I would suggest that when figuring house calls and office visits that Blue Shield recognize that these could be paid in groups rather than individual checks or individual forms for each call. It would seem to me that it would be much better for the insurance company and for the physician filling out the forms to pay for 100 calls (and I have been chastised about the amount of a call here by some of my city friends) at \$5.00 each with one check for \$500 rather than 100 checks for \$5.00. It seems to me that this is the objection that most insurance companies have. They can't pay these small bills; it takes too much money to pay them. I would ask that Blue Shield work it out on an actuarially sound basis. I believe that in the very near future,

Medicare statistics will inform them what is necessary.

I would think it would be well when they plan the packages, that they give alternatives, and not have one large package that might be unwieldy in the beginning, or unthinkable.

I think it would be well for this combined committee to invite such people as Dallas Sells and other union members in to talk about the real desire of the unions in the state of Indiana and, perhaps, to also invite management leaders. I think this program need not be total payment—it could be 80-20 for outside hospital care, and could be \$50 deductible or whatever other program might be desirable.

I am speaking now not of the entire program, because we have those in our area at 80-20 which go clear across the board from office visits on up. I am speaking of the present Blue Shield contract, plus the outpatient care in the office or the home on some such deductible basis for that care alone, but hospitalization coverage just as it is. I think that Project Scope could arrange this.

I think that the committee should look first at what wonderful friends we would suddenly have. It is my feeling that if organized labor strives for this, they can get it, but if no one writes it, they will turn to government for full medical care. I do not believe that organized labor wants to destroy the enterprise system but organized labor leaders certainly want to keep giving something new to their members. Thus, I feel if we have such a plan, we could forestall, if not abate, more socialization. I think we would have friends in labor. For the first time, labor could see the point of view of medicine and would be on our side. We could use a few friends.

After this insurance is written, it should be made known to the public that the ISMA planned and sponsored it. I was questioned—why not say Blue Shield wrote it?—the problems are just exactly as they were before. Let the doctors get credit for it!!

I do not believe that it is necessary for

the committee to go before the House of Delegates to begin study of the program. I think prior to the time we can "claim any fame" for its writing or present it for sale, it would have to go before the House of Delegates.

I realize full well that this is a departure from anything that medicine has done in the past. Medicine, in the past, has waited until the need was most apparent, or even more apparent than they believed, and then tried to act. Since the handwriting is on the wall, and since we know these things to be facts, and since most of us have little interference in our business by third party payments, I believe it is high time that organized medicine did something fruitful and positive for the needs of the people. I could argue this plan before many of you. I suppose that if it is bad, it will be labeled the "Rifner Plan" and if it is good, preferably the "ISMA Plan."

I would urge you to give this deep thought. I would plead with you, as doctors of medicine and as leaders of medicine, to realize the necessity of formulating some type of plan similar to this. If we did this, for once in our lives we would be ahead of the social change, rather than behind it. It has been surprising to me to present this to individual physicians here and there and have them realize that this is a departure but at the same time realize that it would be a step forward.

I do not believe that private insurance will try to come up with such a thing until the necessity is there. I think if we do it ahead of time so that the Blues can say, "yes, we can do this or we can't do that," we can control the changes that occur. Otherwise, I think that suddenly they will want them and we will put out some silly thing like Eldercare, only to be beaten and government take over all medical care.

e. Resolution on organization of AMA delegation: Dr. Kerr presented the following resolution:

BE IT RESOLVED,

1) That the president of the ISMA be

the chairman of the Indiana delegation to the AMA and thus assure our members that their voice is heard

2) That the delegates elect their own floor leader who will undoubtedly be closer to the entire AMA program and that he be in regular and frequent conference with the ISMA president and executive committee to maintain cohesion between the state organization and AMA delegation, and

3) That this procedure be established as the regular process until changed by the Council of the ISMA or the House of Delegates.

This resolution was approved on motion of Dr. Kerr, seconded by many.

Report of AMA Delegates

Dr. Guy A. Owsley, who had been elected floor leader by the delegates, appeared before the Council to discuss matters coming before the June meeting of the American Medical Association and put forth the fact that Dr. Edward R. Annis will be nominated as a member of the Board of Trustees by the Florida delegation and that Dr. Amos N. Johnson will be nominated by North Carolina for the same position, to replace Dr. Homer L. Pearson of Miami, Florida, who has passed away.

Following a detailed discussion of the nominations of Dr. Annis and Dr. Johnson, **upon motion of Dr. Taylor, seconded by several, the delegates were instructed to support the candidacy of Dr. Ed Annis. This action was taken on a roll call vote, which was unanimous.**

There being no further business the meeting was adjourned to meet again at 6:00 p.m., Saturday, July 29, 1967.

Also the Council Committees on Governmental Medical Services, Blue Shield and Emergency Medical Services are to meet at 2:00 p.m., Saturday, July 29, 1967.

The Council will then meet again at 9:00 a.m. on Sunday, July 30, 1967. ◀

COMMERCIAL ANNOUNCEMENTS

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

DESIRED: Associate in practice, to become a partner in an established practice—surgery general and surgery of trauma, and industrial practice. Long established with all necessary equipment in a new office in a new building and a busy growing community. Prefer a man who has completed active duty requirements in service; would feel Naval Reservist would be an extra, but not essential, qualification. If you have the qualifications and are interested, write Box 339, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

EASTERN WISCONSIN CLINIC in rapidly growing community of 50,000 desires board-eligible or certified physicians in obstetrics and gynecology, pediatrics, orthopedic surgery, urology and otolaryngology. Well-equipped clinic and excellent hospital facilities. Lake shore location offers ample recreational facilities. Attractive financial plan leading to early full partnership. Full expenses paid for applicants invited to interview. Call or write: F. L. Hildebrand, M.D., Riverside Clinic, Menasha, Wisconsin.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION**, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

AVAILABLE: Office location for general practitioner or pediatrician. Attractive rental proposition. Located ten minutes from hospital in fastest growing township in Indiana. Contact R. A. Chronister, % Chronister Pharmacy, 6120 Stellohorn Rd., Fort Wayne, Ind. Telephone 219-483-9561.

ANESTHESIOLOGIST: Community of 80,000 in north-central Indiana seeks board-certified or board eligible anesthesiologist. Hospital presently engaged in a construction and remodeling program which will have all new surgical facilities. Interested parties contact Box 340, The Journal, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

GENERAL PHYSICIAN: \$1,540 to \$1,940 a month for regular duty hours in care of patients in a mental hospital. Previous psychiatry training not necessary. Citizenship and license in Indiana. Housing and living benefits on an individually determined basis. Write or phone collect to David P. Morton, M.D., Superintendent, Beatty Memorial Hospital, Westville, Indiana 46391. Phone: (219)-785-7111.

CLINICAL DIRECTOR: To head medical program in progressive 190-bed facility for the retarded. Must have good background in general medicine—experience in pediatrics or internal medicine desirable but not required. Eligibility for Michigan license essential. Hospital located in small community in northern part of lower Michigan—a paradise for hunting, fishing, skiing, and other outdoor activities. Salary up to \$21,400 depending upon qualifications. Excellent fringe benefits and sound personnel policies assured by Michigan civil service. Contact Donald Christensen, M.D., Superintendent, Gaylord State Home, Gaylord, Michigan. Phone (517) 732-5132.

AN EQUAL OPPORTUNITY EMPLOYER

INTERNISTS: Unopposed practice opportunity in town of 17,000 with new 100-bed hospital. Office space immediately available in new professional building. General practitioners also needed. Contact P. E. Doermann, M.D., 1775 N. Jefferson, Huntington, Ind. 46750. Phone (219) 356-4520.

NEEDED:

G. P. in rapidly growing residential community near industrial complex.

Hospital 15 miles — Chicago Loop 60 miles
Lake Michigan 5 miles

Office available — For details
William Robertson, M.D., 600 E. Morgan,
Chesterton, Indiana — Ph. 926-1721 or
Ann Carter — Chesterton 926-1133

AVAILABLE: New office building in Bloomington. Nets over 10%. Can be expanded to include other facilities; \$85,000. Write Box 345, The Journal, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46203 in confidence for details.

SPECIAL NOTICE

June issues and the 1967-68 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis 46208.

Roster: \$3.00 each.

Yearbook: \$5.00 each

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

August 1967

Volume 60

No. 8

Ames Company, Inc.	3rd Cover	National Drug Company, The	1073
Burroughs Wellcome & Co., Inc.	1124	Parke, Davis & Company	2nd Cover
Coca-Cola Company	1116	Pitman-Moore Company	1003
Geigy Pharmaceuticals	1084-85	Poythress, Wm. P. & Co., Inc.	1114-15
Hanger, J. E., Inc.	1113	Professional Life & Casualty Company	1003
Harding Hospital	1053	Robins, A. H. Company, Inc.	1061
Heid's Shoe Store	1120	Roche Laboratories	4th Cover
Hynson, Westcott & Dunning, Inc.	999	Rorer, William H., Inc.	1016
Indiana Medical Bureau	1042	Schering Corporation	1017-20
Lederle Laboratories	1007-08, 1056-57, 1076	Searle, G. D. & Co.	1062-63
Lilly, Eli & Company	1026, 1064-66, 1086-88, 1122-23	Stuart Company, The	1001
Medical Protective Co. of Ft. Wayne	1105	Syntex Laboratories, Inc.	1012-15
Mutual Medical Insurance, Inc.	1055	Wabash Valley Hospital	1011
		Wyeth Laboratories	1034-35

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION
Indianapolis, Indiana

September, 1967

Vol. 60 • No. 9

U.C. MEDICAL CENTER LIBRARY

OCT 16 1967

San Francisco 94122



INDIANA STATE MEDICAL ASSOCIATION

118TH ANNUAL CONVENTION
OCTOBER 9-12, 1967
INDIANAPOLIS

MEMBER

J-0-P
Univ. Of Calif.
Med Ctr Library
Acquisitions Dept.
San Francisco, Calif 94122

12-67

Dilantin® (diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

REACTIONS: Allergic phenomena such as polyarthralgia, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

015R67





LACTINEX[®]

TABLETS & GRANULES

■ to help restore and stabilize
the intestinal flora

■ for fever blisters and canker
sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,^{1, 2, 3, 4} LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.^{5, 6, 7, 8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

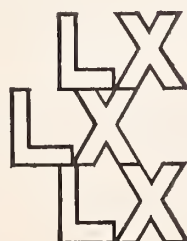
- (1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

**HYNSON, WESTCOTT
& DUNNING, INC.**



BALTIMORE, MARYLAND 21201

(LX04)



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Routine Admission Laboratory Tests in Small Hospitals , Robert W. Christie, M.D., Lancaster, New Hampshire	1173
Comprehensive Health Planning and the Indiana University Medical Center , Kenneth E. Penrod, Provost, Indianapolis	1180
Electrocardiogram of the Month: Right Ventricular Hypertrophy (RVH) in Pulmonary Emphysema , Charles Fisch, M.D., Indianapolis	1184
X-Ray Conference: Vesicorectal Fistula , Erich K. Lang, M.D., Lawrence Allen, M.D., Indianapolis	1185

EDITORIALS

Indiana O and O	1193
The Myth of One-Unit Transfusions (Guest)	1193
Billsbord (Guest)	1194
Editorial Notes	1194

CONVENTION SECTION

Section Begins	1201
Table of Contents to Special Convention Section	1202
Art, Hobby Show Application Form	1152
Scientific Exhibit Application Form	1181
Golf Tournament Registration Form	1186

SPECIAL FEATURES

Doctor! Take the Time! Make the Effort! , Otis R. Bowen, M.D., Bremen	1264
--	------

REGULAR FEATURES

Month in Washington	1145
What's New?	1159
Fourth Estate	1160
Letters to the Editor	1170
President's Page	1196
The Woman's Auxiliary Reports to ISMA	1198
News from Indiana University School of Medicine	1270
Medicine At Law	1275
Wanted: Locations, Physicians	1282
Abstracts, Book Reviews	1290
From The Journal 50 Years Ago	1296
News Notes	1298
Annual Meeting Dates of Professional Medical and Allied Organizations	1303
Board of Health Report	1306
Future Meetings, Seminars, Courses	1308
Deaths	1309

BUSINESS

Executive Committee: July 29, 1967	1310
---	------

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

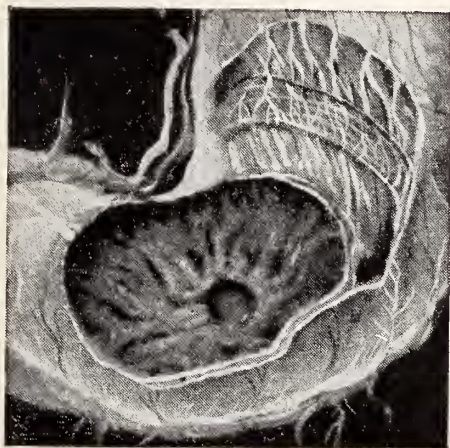
Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Paplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 1195.

In peptic ulcer... antacid therapy with a new benefit



CONTAINS A BALANCED
COMBINATION
OF THE MOST WIDELY
USED ANTACIDS—
FOR RAPID
NEUTRALIZATION.
PLUS SIMETHICONE—
TO CONTROL
THE FACTOR WHICH
ANTACIDS ALONE
CANNOT INFLUENCE.

Mylanta[®]

- In Mylanta, aluminum and magnesium hydroxides are balanced to minimize the chance of constipation or laxation and still achieve rapid acid neutralization and pain relief.
- The positive action of simethicone helps relieve the painful gas symptoms which often accompany the peptic ulcer syndrome.
- The nonfatiguing flavor and smooth, nongritty consistency of tablets and liquid encourage continued patient cooperation during long-term therapy.

Composition: Each Mylanta chewable tablet or teaspoonful (5 ml.) of liquid contains: magnesium hydroxide, 200 mg.; aluminum hydroxide, dried gel, 200 mg.; simethicone, 20 mg. **Dosage:** one or two tablets, well chewed or allowed to dissolve in the mouth, or one or two teaspoonfuls of liquid to be taken between meals and at bedtime.

The Stuart Company, Pasadena, California
Division of Atlas Chemical Industries, Inc.

Stuart

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545

ANNUAL CONVENTION—OCTOBER 9-12, 1967—INDIANAPOLIS

OFFICERS FOR 1967-68

President—Eugene S. Rifner, M.D., Van Buren 46991.

President-Elect—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

Treasurer—Ottis N. Olvey, M.D., 3231 N. Meridian, #11, Indianapolis 46208.

Assistant Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scottsburg 47170.

Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian, Indianapolis 46208.

Legal Counselor—Mr. Robert Hollowell, 1440 Consolidated Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—P. J. V. Corcoran, Evansville.....	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1967
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—William R. Tindall, Shelbyville	Oct. 1967
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1967
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—Milton F. Popp, Fort Wayne	Oct. 1967
13—Otis R. Bowen, Bremen	Oct. 1968

ALTERNATE COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	1967
2—.....
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1967
5—A. W. Cavins, Terre Haute	1967
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1967
9—Clarence G. Kern, Lebanon	Fall, 1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokomo	1969
12—William Clark, Fort Wayne	Spring, 1968
13—George B. Gattman, Elkhart	1967

SECTION OFFICERS 1967-68

Section on Surgery:

Chairman—Joseph C. Finneran, Indianapolis
Vice-chairman—Donald M. Schlegel, Indianapolis
Secretary—Henry Larzelere, Marion

Section on Internal Medicine:

Chairman—Charles M. Sinn, Evansville
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—M. Richard Harding, Indianapolis
Vice-chairman—David E. Brown, Indianapolis
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—Eugene Schmidt, Fort Wayne
Vice-chairman—William M. Matthews, Indianapolis
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Ross Egger, Middletown
Vice-chairman—Jay S. Reese, Martinsville
Secretary—Robert Mouser, Indianapolis

Section on Obstetrics and Gynecology:

Chairman—Joseph F. Thompson, Indianapolis
Vice-chairman—Robert M. Reid, Columbus
Secretary—Tom W. Wachob, Jr., Kokomo

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Richard A. Silver, Indianapolis
Vice-chairman—John A. Robb, Indianapolis
Secretary—Edwin F. Kach, Jr., Muncie

Section on Nervous and Mental Diseases:

Chairman—Donald F. Moore, Indianapolis
Vice-chairman—Hans Meyer, Westville
Secretary—Gene E. Lynn, Indianapolis

Section on Pathology:

Chairman—Joseph L. Haymand, Indianapolis
Vice-chairman—Robert J. Frost, Michigan City
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Roland E. Miller, Lafayette
Vice-chairman—Wendell E. Brawn, Indianapolis
Secretary—Marris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1967:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	James H. Gosman Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumann, Lafayette

New Tareyton 100's with even
more of the taste worth fighting for.
Tareyton-America's largest-
selling charcoal-tip cigarette.



© The American Tobacco Company

ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; Eugene S. Rifner, Van Buren, President; G. O. Larson, LaPorte, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Ottis N. Olvey, Indianapolis, Treasurer; Lester H. Hoyt, Indianapolis, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Clock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis, secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Gootee, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Clock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholtz, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hoyda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Okla W. Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Markleville; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseny, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammond; Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry C. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donald M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordville.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

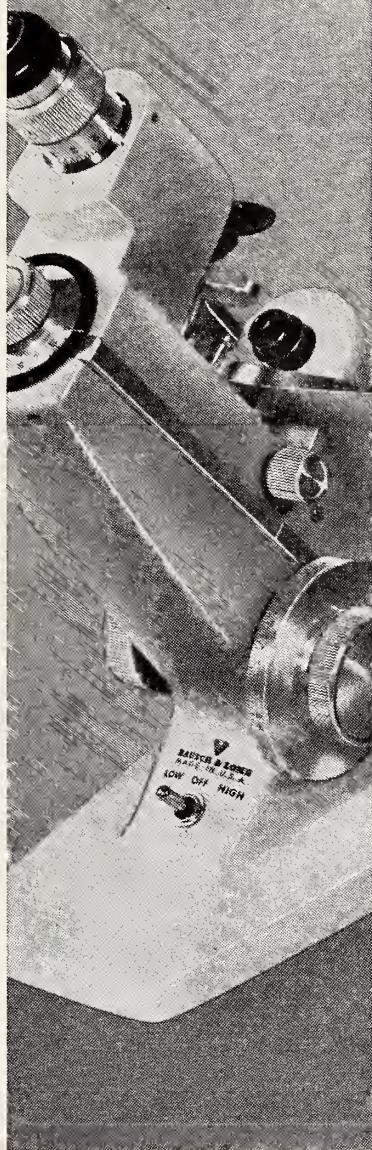
Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Clock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

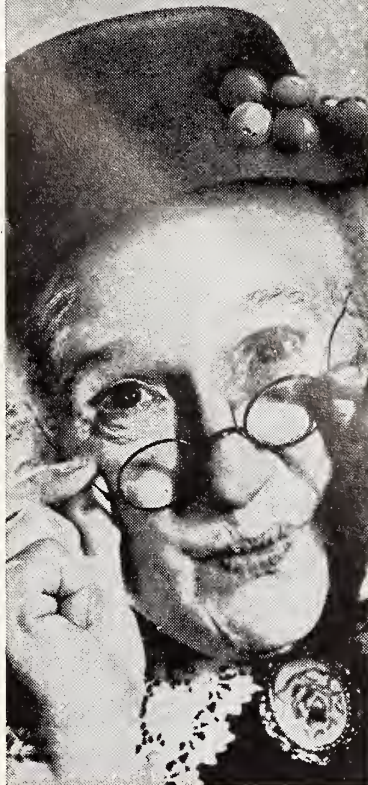
1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Hobgood, Evansville	
2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Connon, New Albany	Elmer L. Wallace, New Albany	
4.	Frank B. Bard, Crothersville	Harold E. Miller, Seymour	
5.	Thomas J. Conway, Terre Haute	Arnold W. Kunkler, Terre Haute	
6.	Paul Inlow, Shelbyville	Perry Seal, Brookville	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	
9.	Harry T. Stout, Frankfort	Earl K. Williams, Frankfort	
10.	R. James Bills, Gory	John J. Reed, Hobart	
11.	Joseph Bean, Logansport	Fred Poehler, Lo Fontaine	Logansport, Sept. 13, 1967
12.	Max M. Gitlin, Bluffton	Berniece Williams, Fort Wayne	
13.	Gordon Cook, South Bend	John Hildebrand, South Bend	South Bend, Sept. 27, 1967

VERTOMETER



MRS. MURPHY



EVERYTHING

*except
Mrs. Murphy*

LENS CLEANER



comes from **WHITE-HAINES**

Her prescription lenses, of course. And the frames.
The vertometer . . . LOOK, our own brand of eye-
glass cleaner.

Whatever you need . . . the finest optical equipment
and accessories . . . White-Haines will supply it.

We call it "depth of service." We supply everything
but the patient!

THE WHITE-HAINES OPTICAL COMPANY

Headquarters: Columbus, Ohio

Serving Ohio • Michigan • Pennsylvania • West
Virginia • Kentucky • Indiana • Illinois • Maryland

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe

Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Griffith Marr, Columbus
A. L. Coddens, Earl Park
Robert H. Wiseheart, Lebanon
Don J. Wagoner, Delphi
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
J. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazey, Washington
Alfred K. Rhodes, Lawrenceburg
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
James Y. McCullough, New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waite, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
James S. McElroy, New Castle
Donald Fields, Kokomo
Barth E. Wheeler, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisett, Madison
George Brown, Greenwood

Boyd K. Black, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford
Robert D. Williams, Markleville
Dwight W. Schuster, Indianapolis

Marshall Stine, Bremen
Parker W. Snyder, Peru
V. C. Viray, Crawfordsville
Ellery T. Drake, Martinsville
John Parker, Goodland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington

John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Clackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Phillip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
H. H. Dunham, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David C. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave.,
Fort Wayne
Mr. Larry L. Pickering, Exec. Secy.,
212 Med. Ctr. Bldg., Fort Wayne
Donald L. Sandlin, 2530 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
James R. McAfee, 1005 N. East, Lebanon
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street,
Logansport

Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St.,
Frankfort

C. Philip Fox, 305 Peoples Bank, Washington
J. Kenneth Jackson, 223 Mechanic St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntington
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman
Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert G. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren
William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St.,
Franklin

John S. Murray, 317 Security Bank Bldg.,
Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave.,
Gary
Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave.,
LaPorte

Joseph D. McPike, 1714 24th St., Bedford
William M. Stimson, 333 Jackson St., Anderson
John O. Butler, 234 E. Southern Ave.,
Indianapolis

Mr. Arthur G. Loftin, Exec. Secy., 2902 N.
Meridian, Indianapolis
Cecil R. Burket, 424 W. South St., Bremen
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 10½ N. Main St., Martinsville
Arthur Schoonveld, Brook
Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Kermit Q. Hibner, 117 N. Grant St.,
Bloomington

Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital,
Valparaiso

Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe,
South Bend

Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E.
3rd., Evansville

Robert L. Meissel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City



fall 1967

DORSEY

Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.^{1,2} Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.¹

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.³ Dr. Jack McKee of the California Institute of Technology⁴ has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.⁵

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,² pulmonary emphysema,⁶ bronchial asthma,⁷ pneumonitis and lung cancer.⁸ Its effect on the incidence of pulmonary tuberculosis is unproved,⁹ although it is conceivable that the

presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.¹⁰

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study² of respiratory illness in a small group of 313 men



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of “air defense” to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, sore-

For nature's hazards:
nasal congestion
due to seasonal
allergies and
summer colds



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

ness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)



at the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,¹¹ an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.¹⁰ Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.¹²

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

References

1. Anderson, R. J. Air Pollution, Respiratory Disease and the NTA, W. Virg. M. J., 60:332, 1964.
2. Angel, J. H., Fletcher, C. M., Hill, I. D., and Tinker, C. M. Respiratory Illness in Factory and Office Workers, Brit. J. Dis. Chest, 59:66, 1965.
3. Waste Disposal Problems Grow, Current Municipal Problems, 8:218, 1966.
4. McKee, J. quoted by Hills, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966.
5. NYC Task Force Revives Concern on Air Pollution, Med. Trib. 7:23 (Sept. 17-18) 1966.
6. Flaxman, N. Pulmonary Emphysema, Med. Trial Tech. Quart. 1960 Annual, p. 221.
7. Heimann, H. Air Pollution and Respiratory Disease, Ann. Allergy 21:396, 1963.
8. Flaxman, N. Pneumonitis and Lung Cancer, Med. Trial Tech. Quart. 1965 Annual, p. 185.
9. Flaxman, N. Pulmonary Tuberculosis, Occupation and Trauma, Med. Trial Tech. Quart. 1959 Annual, p. 237.
10. Hill, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966.
11. Spicer, W. S., Jr. Relation of Air Pollution to Disease, Arch. Environ. Health, 9:600, 1964.
12. Henderson, C. F. What You Can Do To Combat Air Pollution, Parents' Mag. 41:76, 1966.

How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort

Triaminic[®] relieves
summer allergies

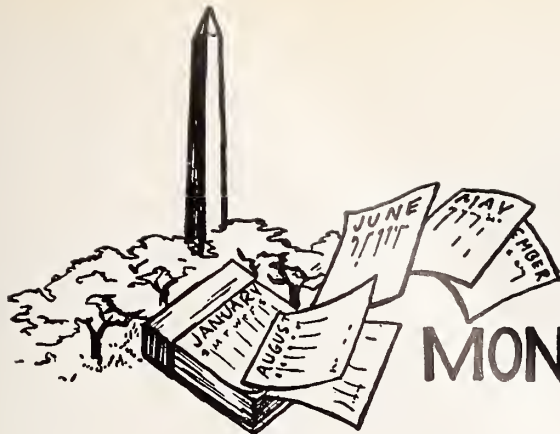
Each timed-release
tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The House Ways and Means Committee approved a social security bill including some medicare and medicaid changes sought by the medical profession and excluding others opposed by the American Medical Association.

THE COMMITTEE also discarded an Administration proposal to extend medicare coverage to disabled workers under age 65, as well as an Administration-opposed proposal that would have put federal government workers under medicare. The actions were part of a general scaling down of the increases in social security benefits sought by President Johnson.


A COMMITTEE bill (H.R. 12080) included these changes in the present law:

- ALLOW medicare patients, or doctors, to collect from the government on the basis of an itemized bill. Present law requires a bill receipted as having been paid to the doctor if the doctor doesn't accept an assignment. (AMA-supported)
- AUTHORIZE states to allow physicians to bill medicaid patients directly if they are not also cash assistance recipients. (AMA-supported)
- ELIMINATE the requirement for certification by a doctor before admission of a medicare patient to a hospital. (AMA-supported)
- SHIFT coverage on medicare outpatient diagnostic services provided by hospitals from Plan A to Plan B. (AMA-supported)
- PUT LIMITS on federal contributions to states for medicaid programs. Beginning July 1, 1968, the federal ceiling on eligibility would be 150% of the annual income set by a state for welfare eligibility. It would drop to 140% on January 1, 1969, and to 133-1/3% January 1, 1970.
- REQUIRE states to give birth control information to welfare patients who request it.

IN ADDITION TO opposing extension of medicare to disabled workers under age 65, the AMA opposed creation of a new Plan C under medi-

Continued on page 1148.





Tissue's healing nicely. Yet anxiety slows his steps toward recovery.

By helping overcome anxiety and tension which can thwart the convalescent's progress, EQUANIL (meprobamate) often may play an important role in medical and surgical aftercare.

Cautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use may result in dependence or habituation in susceptible persons—as ex-addicts, alcoholics, severe psychoneurotics. After prolonged high dosage, drug should be withdrawn gradually to avoid possibly severe withdrawal reactions including epileptiform seizures. Side effects include drowsiness and, rarely, allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute non-thrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If an allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Warn patients of possible reduced alcohol tolerance. Should drowsiness, ataxia, or visual disturbances occur, dose should be reduced. If symptoms persist, patients should not operate vehicles or dangerous machinery. A few cases of leucopenia, usually transient, have been reported following prolonged dosage. Other blood dyscrasias—aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia—have occurred rarely, almost always in the presence of known toxic agents. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. Prescribe very cautiously for patients with suicidal tendencies. Suicidal attempts should be treated with immediate gastric lavage and appropriate supportive therapy.

Contraindications: History of sensitivity to meprobamate.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories
Philadelphia, Pa.



Equanil[®]

(meprobamate)

Wyeth

care and a provision for chiropractor's services—both of which were rejected by the committee.

THE HOUSE group slashed back the President's proposal for a 15% minimum monthly social security increase in cash benefits to 12.5%. The administration proposal for an increase in social security taxes also was scaled down to 4.4% on the employer and on the employee, of the first \$7,600 in wages starting in 1968. The taxable wage base now is \$6,600, and the tax rate is 4.4%. The Administration had asked that the base be increased to \$7,800 next year, and in later stages, to \$10,800.

AMA ASKS EXEMPTION FOR COMMUNITY BLOOD BANKS

THE American Medical Association and the Kansas City (Mo.) Community Blood Bank asked Congress to exempt community blood banks from the anti-trust laws.

REPRESENTATIVES of the groups testified at a senate judiciary subcommittee hearing in support of S.1945 which would amend the anti-trust laws to provide that a nonprofit blood or tissue bank, or hospital, or physician who refuses or who joins together with others in refusing to obtain or to accept delivery of blood, blood plasma, other tissue or organs from any other blood or tissue bank would not be in restraint of trade. The interstate shipment of blood, blood plasma, other tissue or organs also would not be deemed to constitute trade or commerce in commodities.

THE LEGISLATION was introduced after the Federal Trade Commission ruled that a group of Kansas City pathologists, hospitals and blood bank officials had combined illegally to restrain commerce in human whole blood. An appeal against the ruling is pending in the Federal Eighth Circuit Court of Appeals in St. Louis, Missouri.

DR. ROBERT S. MOSSER, president of the Kansas City Blood Bank, said it was inconceivable that groups of physicians may not have the right to discuss shortcomings of medical practice, including the use of blood and its derivatives.

DR. FRANK C. COLEMAN, Tampa, Florida, pathologist, presented the views of the AMA: "BECAUSE serious health hazards may arise through transfusion by virtue of the medical condition of the donor, the care necessary in the selection of blood donors by blood banking facilities cannot be over-emphasized. Serious consequences may arise unless the blood is properly drawn, processed, stored and distributed. And it is imperative that these procedures be performed under high standards, under the guidance and control of proper medical supervision."

DR. COLEMAN pointed out that the AMA in 1963 adopted a statement "to the effect that the transfusion of blood constitutes the transplant of human tissue, and that physicians responsible for transfusions render a medical service to the patient."

"THE HOUSE OF DELEGATES stated that the selection of the donor, the drawing of the blood, its processing and storage, the delivery, the typing and crossmatching, and the administration of the transfusion and the evaluation of its effects, were functions intimately involving medical judgment and requiring medical supervision," Dr. Coleman said.

"THE American Medical Association believes that the health interests of the community are best served when the supply of blood is maintained on a replacement basis. We feel that the patient, the donor and the public benefit when blood is replaced by the patient, his family or his friends in the various organizations of which he is a member.

"SINCE the consequences of any abuses can be tragic, it is our opinion that the physician and hospital must have available to them every means of insuring the safety of the patient."

AMA OPPOSES TAXING OF ADVERTISING REVENUE OF NON-PROFIT ASSOCIATIONS

THE American Medical Association and the Missouri State Medical Association argued against an Internal Revenue Service proposal to tax the advertising revenues of publications of non-profit associations.

REPRESENTATIVES of other affected, non-medical organizations also opposed the proposed tax at an IRS hearing.

BERNARD D. HIRSH, director of the AMA's Law Division, pointed out that the pertinent law on unrelated income had been on the books for 17 years without any such tax being proposed by the government.

"THE PROPOSED regulations go beyond the law, first in arbitrarily classifying all advertising contained in trade and professional journals as unrelated, and secondly, in treating income derived from this source as if it were income from a business capable of separate existence," Hirsh said.

DR. HECTOR W. BENOIT, JR., MSMA President, noted that one of the states purposes of the proposal was to eliminate alleged unfair competition in advertising between non-profit association journals and profit magazines.

"IF you have the stomach to read many of these advertisements (in Missouri Medicine), you will find they are directed purely to a professional audience and would be unlikely to enhance the public appeal to such lay publications as Atlantic Monthly, Look, etc. . .," Dr. Benoit said.

HE ALSO NOTED that medical societies furnish many voluntary services for their communities, as well as provide physicians with much of their latest information on medical advances.

"WITHOUT the help of the advertising income from these publications

and the income of exhibitors at these medical meetings, many of these sources of educational information would be severely restricted, even indeed in many instances, eliminated entirely," he said.

PHS REPORTS HOSPITALS NEED MODERNIZING

THE PUBLIC HEALTH SERVICE reported that, according to Hill-Burton state agencies, 3,327 of the nation's 6,716 general hospitals need modernization or replacement of facilities for 272,000 of their beds. Of the total, replacements is required for 70,000.

BUT Dr. William Stewart, PHS Surgeon General, said that replacement or modernization was not the complete answer.

"DEVELOPMENT of alternative care facilities, earlier preventive treatment, increased and more readily available outpatient services—all of these may offer a better solution to a given hospital's problems," he said.

DR. STEWART said 143 hospitals in the survey were critically overcrowded with average annual occupancy rates of 90% or more of reasonable capacity. Another 1,289 hospitals had occupancy rates of between 80 and 90%, "substantially above the national average."

"ANY HOSPITAL experiencing an average annual occupancy rate of 90% or more exceeds the safe limit," he said.

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

W. R. VanDenBosch, M.D.

(Phone)

447-6404

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

David L. Evans, M.D.

743-1809

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

**Pick one to die.
Pick one for jail.
Pick one to waste away.
Pick three for happiness.**



Some children find happiness easily. Others need the help and guidance only a trained person can provide, medical attention they cannot afford, love they have been denied. When you decide to give to your United Fund or Community Chest, you may change a life.

Your fair share gift works many wonders/THE UNITED WAY



Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1967 annual meeting of the Indiana State Medical Association, Oct. 9-12 at Indianapolis for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Dr. Ray H. Burnikel
517 Sycamore St.
Evansville

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Drs. Schneider and Burnikel, co-chairmen.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

We solicit your exhibit to make this the largest and best ever this year.

Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville

Name_____

Address_____

City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

Two ways to give your patients a month's therapeutic supply of vitamin C:



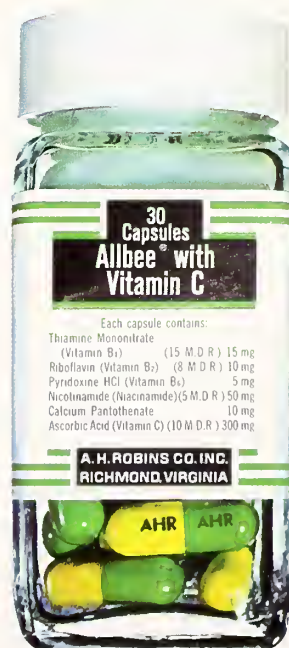
118 grapefruit or 30 Allbee® with C

Your patient would have to eat 118 medium-sized grapefruit (almost 4 a day!) to get as much vitamin C as is provided in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule supplies full therapeutic amounts of the B-complex vitamins.

Your patients can purchase Allbee with C capsules in the convenient bottle of thirty—a month's supply at a very reasonable price. Also the economy size of 100. Available at pharmacies everywhere on your prescription or recommendation.

A-H-ROBINS

A. H. Robins Company, Richmond, Virginia



the spasm
reactors
in your practice
deserve

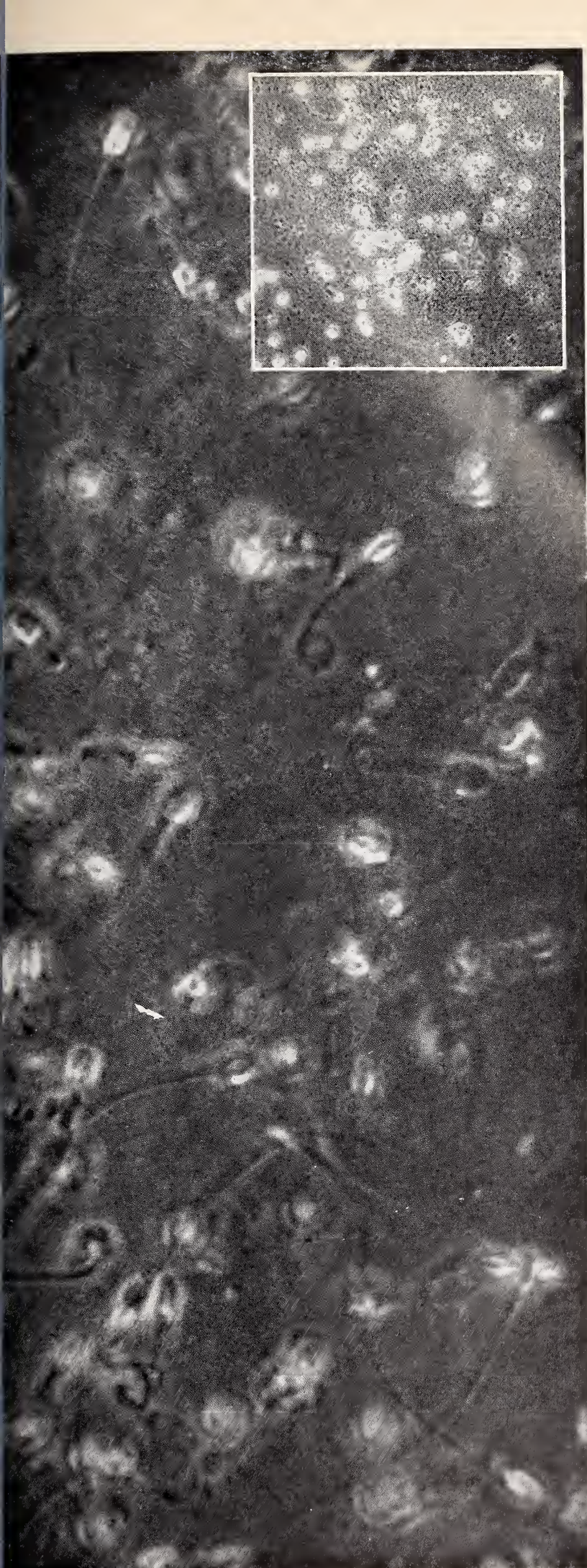


"the Donnatal Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0582 mg.
hysocine hydrobromide	0.0065 mg.	0.0195 mg.
phenobarbital (¼ gr.)	16.2 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)		

Brief summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

New view of an oral contraceptive at work



Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1— a combination of both low-dosage progestogen and estrogen for the full treatment cycle— may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

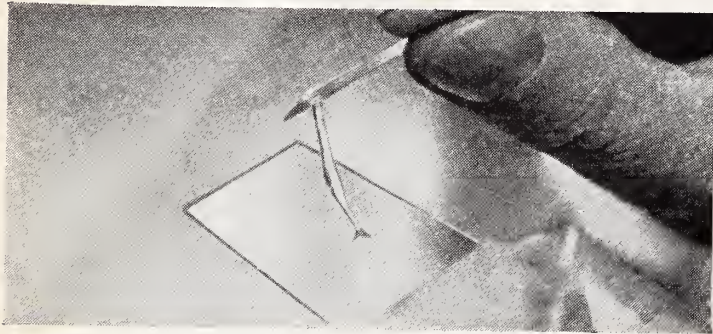
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

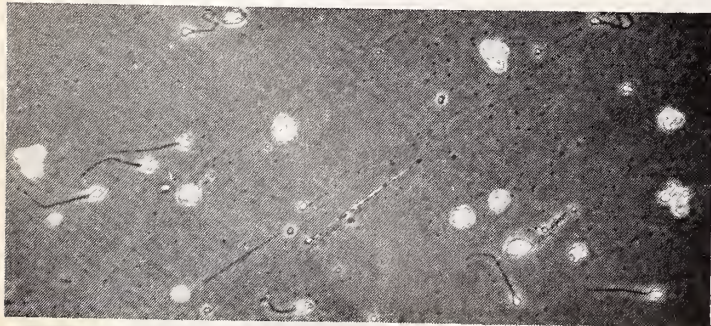
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.



Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

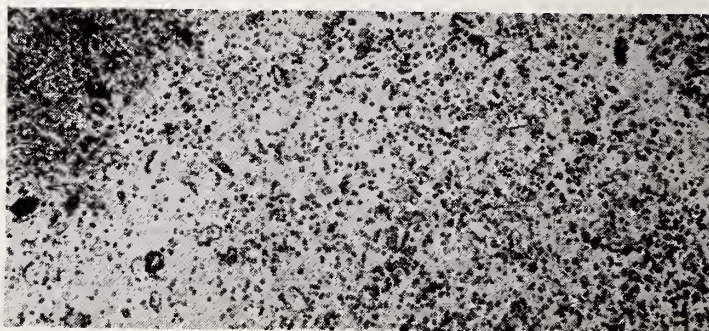


Spermatozoa appear healthy, are active and freemoving.

Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

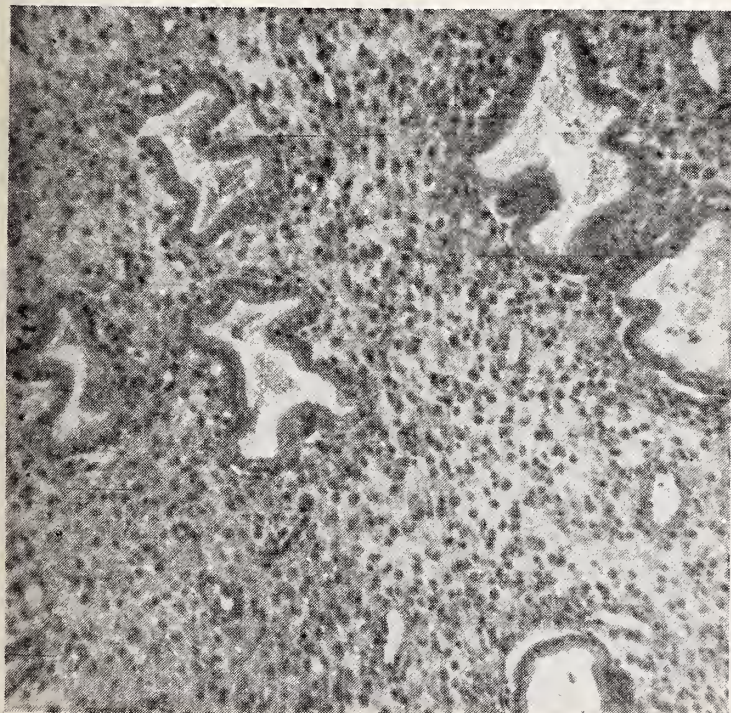


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

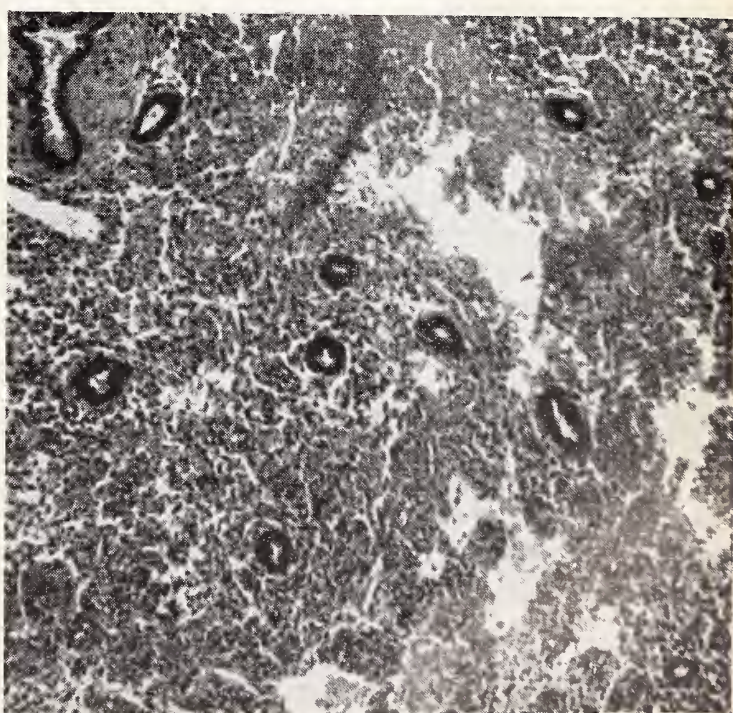
How Norinyl-1 alters normal endometrial responses— another possible protective mechanism

Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of
untreated patient



Endometrium produced
by Norinyl-1



Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl-1[®]

(norethindrone 1mg. \bar{c} mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which *both* norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.05 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are

indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be

altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T³ values), metapyrone test, pregnane diol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. For complete clinical data, see package insert.

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle. (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20-day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 5 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.)—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from

SYNTEX

LABORATORIES INC., PALO ALTO, CALIF.

What's New?

A. H. Robins is introducing Allbee®-T, a high potency formulation of the important B-complex vitamins, including Vitamin B₁₂, with 500 mg of Vitamin C and desiccated liver. Allbee-T is recommended for conditions in which the intake and/or absorption of the water-soluble vitamins may be impaired, but is not intended for the treatment of pernicious anemia.

* * *

A neat, durable and disposable nurses' smock is being supplied by Professional Disposable Products of Mount Vernon, New York. Strength is achieved by reinforcing the non-woven material with nylon yarn. The garment is said to be cool, comfortable and attractive. The disposable feature eliminates the expense of mending and laundering.

* * *

Eli Lilly announces another decrease in the price of V-Cillin K. The average price of the tablets has been reduced by 20%, and the various pediatric preparations by 10%. This is the fourth general price reduction for V-Cillin K since 1959 and brings the current prices to less than one-half those of eight years ago.

* * *

Rotating circular files, made by the Wassell Organization of Westport, Connecticut, will accommodate almost twice the number of x-ray negatives as could be filed in conventional file cabinets and drawers in the same floor space. The negatives are said to be easier to locate and extract when filed in the circular file. Adding more tiers on top of the circular files further increases the floorspace saving feature.

* * *

Pfizer announces the approval by FDA of a new drug, Navane, as a new and potent antipsychotic agent for the treatment of acute and chronic schizophrenic patients. The generic name is thiothixene. Double-blind trials were used to demonstrate its effectiveness. It is not recommended for use in children and is contraindicated in patients with circulatory collapse, comatose states, central nervous system depression due to any cause, blood dyscrasias and in individuals who have shown hypersensitivity to the drug.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



What can be done for Susan Jane To stop the runs and crampy pain?

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa.

In children, Parepectolin may be used to control diarrhea promptly and prevent dehydration, until etiology has been determined. In some cases, Parepectolin may be all the therapy necessary.

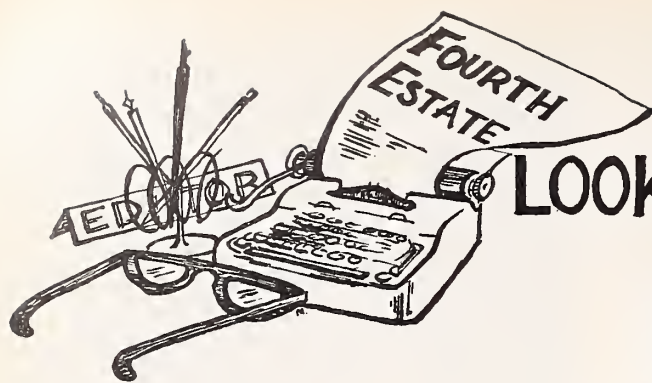


Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium (¼ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Children's Dose: One or two teaspoonfuls
three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



LOOKS AT MEDICINE

This section of *THE JOURNAL* is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

As Others See It: AMA's Drug Survey

The results of the American Medical Association's survey of drug prices in Chicago must have surprised even the doctors. . . .

The survey . . . showed that while drugs prescribed by brand names are usually priced higher than drugs prescribed by their generic names, the reverse is often true and that prescriptions by generic names are more often than not filled with brand name drugs.

But the importance of the survey goes beyond its immediate results. It shows how misguided some of the snap assumptions made in Washington can be. Ever since the late Sen. Kefauver began hauling drug manufacturers onto the congressional carpet, it has been a tenet of "liberal" politicians and planners that the prices of prescribed medicines, especially those sold under brand names, are unconscionably high and that the manufacturers are to blame.

It would be just as naive, of course, to assume that all retail druggists are profiteers as to assume that all manufacturers are pure as the driven tetra-cycline. There are often legitimate reasons why one druggist charges more than another for the same product. . . .

But the variation found by the AMA is more than these factors can justify. The fact that it does exist suggests, odd as it may seem, that there is less effective competition among the country's innumerable retail druggists, when it comes to sell-

ing prescription medicines, than there is among the big manufacturers. And there is an explanation for this: Namely, that a housewife with a prescription to be filled rarely shops around at competing drug stores. She takes it to the store where she is known, or which is nearest, or which happens to be open. And, having had it filled, she probably won't remember what it said [if she could read it] and will therefore never know how the price she paid compares with what she might have paid elsewhere. . . . — *Chicago Tribune*. Reprinted in *The AMA News*, June 19, 1967.

Alarming M.D. Shortage

The U. S. shortage of doctors has reached "alarming proportions."

Says who? Says the American Medical Association, a group sometimes accused of trying to limit the size of the M.D. "club."

The AMA is so concerned about the doctor shortage that it is recommending "an immediate and unprecedented increase in physician output," both by increasing enrollments at existing medical schools and by building new schools.

In Indiana, where the state's lone medical school is at a size which some critics think exceeds the point of efficiency, there is only one logical way to move. That is to build at least one more medical school.

AMA figures show that the United States is currently graduating 7,600 new physicians annually. Just to keep the physician-patient ratio unchanged at 150 per 100,000 will require an in-

crease to 11,000 new physicians a year by 1975.

Indiana lost a chance to help ease the doctor shortage last winter, when Gov. Roger Branigin vetoed a blue-ribbon site selection committee authorized by the 1967 General Assembly.

Perhaps the AMA's "immediate and unprecedented" drive for more doctors will help persuade our state to do what it ought to be doing right now — working toward the earliest possible creation of a second medical school. — *South Bend Tribune*, June 26, 1967.

Abortion—The AMA's View

The AMA, meeting at Atlantic City, told the nation's doctors it is ethical to perform abortions under a number of liberalized conditions. The association's policy statement permits therapeutic abortion to save the health or life of a patient or to prevent the birth of a severely crippled, deformed, or abnormal infant. Under the new policy, physicians could ethically perform abortions when a pregnancy threatens the mental health of the woman.

It is to be noted that the points contained in the AMA's policy statement are nearly identical with those approved by both houses of the Indiana General Assembly.

The reasons behind the policy statement of the AMA are worth examining. One of the purposes of the policy is to provide an ethical justification for abortions performed by many doctors even when they violate

state law. The AMA's committee on human reproduction, which drew up the policy statement, estimates 10,000 abortions are performed yearly by licensed doctors and adds that few of these are necessary to save the mother's life.

"American medicine is therefore confronted with the situation whereby conscientious practitioners performing therapeutic abortions for reasons other than those posing a direct threat to the life of the mother are acting contrary to existing law," the committee said.

The AMA acknowledges that there are many doctors who oppose therapeutic abortion under any circumstances for moral or religious reasons. It does not suggest that physicians or patients act contrary to their personal consciences.

The 14-page policy report takes notice of the view of the Roman Catholic Church and other religious bodies who oppose abortion under any circumstances and says "the committee respects the right of these groups to express and practice its belief.

"However, the committee believes that physicians who hold other views should be legally able to exercise sound medical judgment which they and their colleagues feel to be in the best interest of the patient."

In guidelines established by the AMA committee, documented medical evidence should be presented and two other physicians should concur with the patient's doctor on the necessity for an abortion. Also the operation should be performed in an accredited hospital.

The action of the AMA serves to clear some of the taboos which have surrounded this controversial subject and the action may establish a precedent which many state legislatures may adopt when next they consider liberalizing their abortion laws. — *Muncie Star*, June 30, 1967.

"Advertising" Doctors

The following letter was received

this week, and is given in full.

To the Editor:

Since I have recovered from eye surgery and can see so good for the first time in years, I'm wondering if we of Adams County really realize and appreciate our local hospital and the wonderful doctors and nurses we have here. Most of our local doctors are men who grew up around Decatur. So too our nurses, the help and management of the office, cooks etc. all around the hospital are from around the county. I had such wonderful care and am so grateful we have an eye specialist, Dr. Parrish, so we didn't have to travel to some distant place.

I suppose there must be some ethical reason why the names of our local doctors and dentists and specialists are not ever published in our paper. Why could not a list of these names be given in our paper so people would know who to call when the need arises. The Welcome Wagon, I understand give [sic] this information to newcomers in the city, but the people outside in the country often do not know where to go, especially in an emergency, or when an accident happens.

Sincerely,

Mrs. Ervin Lochner

Mrs. Lochner is quite right on both points—our local doctors and nurses, etc., do a fine job — and also, they are opposed, on the grounds of ethics, to the publishing of their names and specialties in the newspaper. It is their ethics that opposes this, not those of the newspaper. For many years, all doctors ran daily or weekly advertisements giving their hours and specialties.

But the medical societies decided this wasn't professional, and forced them to quit it. Now they only advertise when they are going to be out of their offices, not when they are going to be in! Many even object to their specialty — such as M.D or D.D.S. — being mentioned with their names in news stories.

We would suggest, that when an

accident happens, a telephone call be placed immediately to the local hospital, alerting them to what has happened, and the type of accident or illness being brought in. A physician or surgeon is more quickly located there than at his home or office, and one is always on call. Every telephone should be plainly marked with the hospital, fire and police or sheriff's number — and many have an ambulance service number on them, too.

In the case of an emergency, it is much more important that a physician's help be received promptly than it is to decide WHICH physician should do the treating. All physicians allowed to practice at the Adams county memorial hospital are properly licensed and competent to serve the general public. — *Decatur Democrat*, June 28, 1967.

Doctor Shortage Nears "Alarming" Stage

There are not enough physicians in the United States. Those we do have tend to concentrate in cities and more prosperous areas, so that there is a marked shortage of medical care in some parts of the country.

A determined and sustained effort ought to be made both to increase the number of doctors proportionate to total population, and to improve geographic distribution of medical services.

This has been a matter of concern to well informed persons for years, even for decades. During much of that period there have been recurrent charges that organized medicine, through the American Medical Association, has sought to limit the supply of physicians.

Whether or not this was true is now a matter of history: the AMA has publicly aligned itself with those who believe the nation must act to train a lot more doctors than are now being trained.

The AMA's Board of Trustees stated its feelings in the strongest terms. It said the national shortage

of doctors was reaching "alarming proportions," and urged "an immediate and unprecedented increase" in medical school enrollments.

It is significant that the AMA committee which studied medical manpower needs concluded that the shortage also covered other health personnel — nurses and the like. That jibes with the findings of government experts. They would like to see a dramatic increase in health personnel all along the line.

Further impetus to this move will be forthcoming next fall when the National Advisory Commission on Health Manpower makes its report. Meanwhile, it is heartening to know that the AMA is aware of the situation and intends to put its shoulder to the wheel. — *Evansville Courier*, June 28, 1967.

Catching Up

The board of trustees of the American Medical Association terms the national shortage of physicians alarming and calls for still more and better medical schools to meet the shortage.

Other health authorities continue to decry the doctor shortage. Yet in the last decade, even with six new medical schools and some expansion of older ones, the number of physicians graduated each year has risen only from 6,800 to 7,600.

Importing about 1,500 doctors a year helps, but the Health, Education and Welfare Department estimates it will take 11,000 graduates a year by 1975 just to keep up with population growth. And to provide adequate medical attention, the department calculates, would require 50,000 more doctors right now.

Not only are Americans more aware of the importance of good medical attention but increased affluence, together with insurance and welfare programs, has made them better able to pay for it. Patients should welcome any action that means less time in the waiting room. — *Terre Haute Star*, July 6, 1967.

We Can End Measles

An exhibit at the annual convention of the American Medical Association laid it right on the line about measles: Americans have it in their power to eradicate this serious childhood disease within 10 or 12 years through mass immunization; otherwise eliminating it will take five years longer. That projection is even more impressive when translated into cases — about seven million more, if we choose the slow route.

Several measles immunization clinics, with free vaccine being provided, have been staged in the Lafayette area.

The key fact is that, though we now have an effective measles vaccine, its true effectiveness depends on mass use. Poliomyelitis was substantially eliminated in about eight years, thanks to mass immunization programs, but the task would have taken much longer without them. For example, it took 40 years to bring whooping cough and diphtheria to the very low present level of incidence.

Those responsible for the exhibit at the AMA convention offered chilling insight into what failure to conduct mass measles immunization will mean. Out of the estimated seven million cases that will result if the mass approach is not used, it was said, complications could be expected to cause more than 700 deaths, about 2,300 cases of mental retardation and about 7,400 cases of encephalitis.

Measles is on the decline already, thanks largely to mass immunization programs in 150 communities in the past 18 months. But about seven million American children remain susceptible to measles, and in some states incidence of the disease is greater than the average of recent years. Medical science has given us a chance to do away with this disease which cuts a swathe among the very young. We should make the most of it. — *Lafayette Journal & Courier*, July 6, 1967.

The Doctor Shortage

The shortage of doctors is approaching the critical stage in several Bloomington-area towns and the situation is growing worse, not better.

To help overcome the problem, caused largely by young doctors' reluctance to open practice in smaller communities away from modern medical facilities — and decidedly lower-paying — Indiana University is beginning a revolutionary program that will have junior year medical students aid medical staffs in rural areas. But this program, which can literally be life-saving, can only work if residents of the areas take advantage of it, realizing that a junior in medical school is better trained than full-fledged doctors in most countries.

And that the students are fully aware of the need to refer more complex cases to practicing M.D.'s.

The American Medical Association is so concerned about the doctor shortage that it is recommending "an immediate and unprecedented increase in physician output," both by increasing enrollments at existing medical schools and by building new schools.

AMA figures show that the United States is currently graduating 7,600 new physicians annually. Just to keep the physician-patient ratio unchanged at 150 per 100,000 will require an increase to 11,000 new physicians a year by 1975.

The problem of too few doctors in less urbanized areas is complex and new solutions must be found. I.U.'s program is a good start and other new ideas must be tried to solve the dilemma. — *Bloomington Herald-Telephone*, June 28, 1967.

The Drinking Driver Survey

Research into the alcoholic beverage factor as it pertains to motorists will begin in Howard County Wednesday.

From 2,000 to 3,000 drivers will be stopped over a three-month period, to determine why a driver drinks

Continued on page 1169.

A Building Block approach to treating hypertension



With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide



A single daily dose of Enduron provides sodium excretion around the clock





Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day
ENDURON®
METHYLOTHIAZIDE



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	 2.5 mg. tablet	 5 mg. tablet	 7.5 mg.	 10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl



The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmony[®]), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

Once a day, every day









ENDURONYL[®]

METHYLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	 2.5 mg. methylothiazide 0.125 mg. deserpidine	 5 mg. methylothiazide 0.25 mg. deserpidine	 7.5 mg. methylothiazide 0.375 mg. deserpidine	 10 mg. methylothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	 2.5 mg. methylothiazide 0.25 mg. deserpidine	 5 mg. methylothiazide 0.5 mg. deserpidine	 7.5 mg. methylothiazide 0.75 mg. deserpidine	 10 mg. methylothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

707075-R

Eutonyl affords a different kind of basic therapy for moderate to severe cases



Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.^{1,2}

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.

Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY
DOSAGE
RANGE

Minimum



10 mg. tablet

Usual starting



25 mg. tablet

Intermediate



50 mg. tablet
or as needed

Maximum



200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.

2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects



Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.





A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

Once a day, every day

EUTRON™
PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCHLOTHIAZIDE 5 MG.



	Minimum	Usual starting	Intermediate	Maximum
DAILY DOSAGE RANGE	 12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide	 25 mg. pargyline hydrochloride and 5 mg. methyclothiazide	 37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide	 50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

See Brief Summary on final page of advertisement.

TM—Trademark

707075-R

ENDURON[®]

METHYLOTHIAZIDE

ENDURONYL[®]

Each tablet contains
Methylothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL[®]

PARGYLINE HYDROCHLORIDE

EUTRON[™]

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methylothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyl dopa. 2 week interval should separate therapy and use of these agents.

Methylothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery 1/4 to 1/2 the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R



FOURTH ESTATE

Continued

rather than if he does, *The Kokomo Tribune* reports.

Motorists will be stopped at random in selected locations, but will not be required to submit to interview. Answers will be strictly confidential.

Types of questions to be asked will include the religious affiliation of the driver, since it could have a bearing on drinking practices; how much the motorist thinks he can drink before the law says he is intoxicated; and how often he drinks that amount.

"Since alcohol is involved in roughly 50% of the fatal traffic crashes in United States," says Dr. Robert Borkenstein, director of the Indiana University department of police administration, "we hope that data assembled by this project can be useful in cutting down that toll."

How useful the project can be will depend much upon extent of voluntary cooperation by those interviewed and their frankness. We hope this won't parallel the case of voluntary auto safety checks, wherein many drivers most needing the checks stay away.

Indiana law says that a .15 or more alcoholic content of the blood is prima facie evidence of intoxication, and drivers with this amount or more are arrested automatically; they are subject to arrest on .10 to .14, depending upon the traffic circumstances and the driver's physical condition at the time.

The experience in Elkhart (and we imagine elsewhere, too) is that motorists thus arrested rarely believe they have been drinking to the extent it would impair their driving judgment — even when the breathalyzer shows them to be over the legally tolerable limit of blood alcohol.

Too many thus have a confidence in their ability unwarranted by the facts.

The need is for a more realistic appraisal of one's self in all such circumstances. "When you drive, don't

drink; when you drink, don't drive" still is the best advice.

Perhaps the survey in the Kokomo area will at least help increase the general awareness of this problem. — *Elkhart Truth*. Reprinted in *The Kokomo Tribune*, July 5, 1967.

The AMA Decides— Or Does It?

The heads of three "national" medical organizations, with none of which we are familiar, have attacked Dr. Milford O. Rouse, the new president of the American Medical Association, for continued opposition to Medicare and Federal intervention in the entire field of health and medicine.

The surprising aspect of the attack on the AMA is not that it occurred, for each of the three groups is relatively small, and their very names — the Medical Committee for Human Rights, the National Medical Association, and the Physicians Forum — suggest that they function in a dual or competitive role to the almost-all-embracing AMA.

However, we were a little taken aback by the joint blast at Dr. Rouse because his attackers suggest that in opposing Medicare there is some basic contradiction of the Hippocratic Oath.

If the presidents of the MCHR, the NMA, and the PF had bothered to research the matter a bit, they would have discovered that the Hippocratic Oath has precious little to say about the economics of medicine except that the physician is bound to teach the medical arts to the offspring of his preceptor, if they so desire, without fee or covenant, and to contribute, if need be, to the support of his preceptor. Since medical education has long since moved out of the area of an exclusive teacher-student relationship, that phase of the oath has little practical application.

If the AMA were to be indicted on the basis of the Hippocratic Oath, its detractors should have chosen to pink it in a more sensitive area.

There is, for example, the AMA's

new position on the liberalization of abortion laws, taken last week by the organization's House of Delegates in session at Atlantic City.

The New York Times, which is, itself, four-square for easing of abortion restraints, reported the AMA took an "unequivocal stand" in favor of liberalizing abortion laws. It went on to state that new association policy condones abortion "to safeguard the health or life of the mother; to prevent the birth of a child with a physical or mental defect; and to terminate pregnancies resulting from rape or incest."

The new policy apparently follows the model penal code of the American Law Institute in that it would condone only abortions induced in an accredited hospital by a licensed physician, with concurring opinions of two other qualified doctors.

Now, the Hippocratic Oath is equally unequivocal on the subject of abortion, for, translated to English, it states in no uncertain terms:

"I will give no deadly drug to any, though it be asked of me, nor will I counsel such (apparently an injunction against assisting in homicide or suicide), and especially, I will not aid a woman to procure abortion."

Despite the assessment of the *Times*, the AMA did equivocate in its abortion policy, for it notes and "respects" the position of the Roman Catholic Church on the subject and establishes the "right of this group to express and practice its belief."

The AMA, in fact, equivocated completely on the subject of abortion, for its policy continues:

"However, the AMA believes that physicians who hold other views should be legally able to exercise sound medical judgment which they and their colleagues feel to be in the best interest of the patient."

In short, the AMA, when confronted by the great medical and moral questions of abortion, has confused

the two, has answered neither, and has kicked the whole matter back to its individual members. How equivocal can the AMA be?

In the meantime, what, if any, bearing does the Hippocratic Oath have on the practice of medicine today? — *Fort Wayne News-Sentinel*, June 29, 1967. ◀

Accident Prevention

Most of us think of a traffic accident as happening very suddenly. To the driver and his passengers it does seem sudden. However, the more we are able to understand accidents, the more we can observe that accidents and their consequent injuries result from a sequence of events that begin a long time before.

Even though we don't know as much as we should about these events, it seems reasonable that there are many steps that we can take—not only as drivers, but as voters, taxpayers, consumers, parents, even as passengers—to try to interrupt this sequence.

New laws have been passed in an attempt to reduce the tragic toll on America's highways. More are needed. Last year 52,500 deaths and 4,400,000 injuries resulted from traffic accidents. The economic loss caused by these accidents amounted to \$9.8 billion.

According to an authoritative report from The Travelers Insurance Companies, research is essential. It must be coupled with the new laws, better law enforcement and a greater stress on driver education.

Research can tell us why and how accidents will occur. Their prevention is still largely up to the driver.

Letters

to the editor

July 13, 1967

Dear Doctor Ramsey:

We are General Agents in the United States for Port Line Ltd., a British Flag carrier with a fleet of some 33 vessels, who maintain regular freight services between the United States and Canadian ports and ports in Australia and New Zealand.

Some of the vessels employed in this trade carry no passengers while others may carry up to 12, however, in all instances the services of a ship's surgeon are desired.

We are wondering whether you might wish to include in your publication, as a point of information to your readers, the fact that we are interested in obtaining the services of doctors who may be in the United States doing postgraduate or other further study work and who are desirous of returning, say to Australia or New Zealand, which transportation we would provide in exchange for their medical services on board ship. Doctors, whether male or female, are signed on Articles and become, in effect, a member of the vessel's crew. Should the interested doctor be of a nationality other than Australian or New Zealand, in many instances he might be, in all likelihood, again signed on a vessel proceeding from Australia or New Zealand to the U.K. or Continent after the voyage from America.

Doctors who are interested should contact us at the following address:

Port Line Ltd.
c/o Funch, Edye & Co., Inc.
25 Broadway
New York, N. Y. 10004
Att: Mr. L. J. Eble

We would appreciate any assistance you might be able to provide.

Yours very truly,
(s) Funch, Edye & Co., Inc.

To the Editor:

Last Monday evening we lost our doctor. [Elton R. Clarke, M.D., Kokomo.] We also lost a friend. He was never too busy or hurried to talk or just to hear what you had to say. He made one feel special. Yes, he liked us ordinary folks.

His familiar hearty laugh rang out in the office or hospital. I sure hope there is a sense of humor in Heaven (and I believe there is) for his laughter was like a tonic for us.

He was faithful. We'd call him when we had sickness and if at all possible he was right there. Money certainly was of secondary importance to this man of right values.

He loved children and his baby clinic was his joy. Our Lord tells us "of such is the Kingdom of Heaven." He will be right at home there.

Reading the newspaper accounts of his death, I realized the various honors and accomplishments of Dr. Clarke. But the most important attribute was, I believe, his love for the common man. It makes one realize the things unseen by the crowd when done well is the best testimony of what a man is really like.

I know he will hear Our Lord say, "Well done, thou good and faithful servant — enter thou into the joy of thy Lord."

A grateful patient

P.S. Please don't print my name because this letter might have come from any of his patients. — *Kokomo Morning Times*, May 23, 1967. ◀



*"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."*

Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract.

Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP

DOW **PITMAN-MOORE** Division of The Dow Chemical Company, Indianapolis

easy does it!

tear, moisten, compare—that's all!



Reliable automated laboratory equipment makes it possible to do an increased number of hematological and metabolic tests on a routine admission basis, with a reduced unit cost and an overall cost which is more than compensated by the increased clinical knowledge which the tests afford.

Routine Admission Laboratory Tests in Small Hospitals*

ROBERT W. CHRISTIE, M.D.
Lancaster, New Hampshire

SINCE many physicians now advocate routine laboratory tests as a preventive form of medicine for patients admitted to the hospital, it is apparent that this is a subject which deserves exposition. However, a recent editorial in *The New England Journal of Medicine*⁴ regarding routine laboratory tests has brought into focus several interesting aspects of the problem and emphasizes Jean Mayer's recent statement: "We are not yet used to thinking of subjecting our whole population to competent and continuous preventive care. . . ."⁸

For many years it has been a standard of the Joint Commission on Accreditation of Hospitals that medical staffs require certain minimal laboratory tests⁵ as well as a history and physical examination⁶ on all patients admitted to the hospital. The commission further states that "physicians and hospitals should be interested in total patient care. Good patient care

requires an assessment of all of the systems of the body, not just that area in which there is evident pathology."⁷

Most hospital medical staffs have interpreted this to mean that at least a blood count and urinalysis should be performed on every patient admitted, and many hospital staffs have extended the concept to include a serological test for syphilis and other screening diagnostic procedures such as electrocardiograms and chest x-rays for selected groups of patients.

Thirty or more years ago, because of limitations of equipment, techniques and personnel, the complete blood count, urinalysis and syphilis serology were accepted as a reasonable extension of the examination conducted by the patient's physician. Now, with well trained laboratory personnel, refined microbiological, serological and biochemical techniques and automated equipment, it is possible to go far beyond this, and in enlightened areas, at a much reduced cost to the patient.

Results from laboratory tests can usually be obtained so quickly that within hours there will be a battery of information on the chart for use by the attending physician in evaluating his patient's total medical situation.

Such machines as automatic cell counters, automatic blood chemical analyzers, clot timers and pH meters, as well as screening techniques for detecting certain types of bacteriological infections of the bowel, urinary tract or other body cavities, now make this rapid gathering of information possible. Periodic health examination using an automated multitest laboratory employing many of these techniques for outpatients at a large medical clinic³ has recently been described.

Economic Factors

Because so many laboratory tests can now be automated, it is possible to reduce the unit cost to the patient, and although the total laboratory bill may sometimes be higher, the cost per

* Presented at the New England Society of Pathologists meeting, Boston, Mass., May 9, 1967.

unit test drops precipitously when large numbers of samples are processed automatically. It can be argued that this additional expense should be of concern to only the attending physician and the patient himself. Experience has shown, however, that when panels are designed but left to the discretion of the individual physician for use, the panels are rarely ordered, and the laboratories are frequently underutilized.

In smaller hospitals particularly, the economics of providing quality laboratory data depends upon a sufficient volume to obtain enough revenue to employ registered medical technologists and certified laboratory technicians, as well as underwriting the cost of quality control programs. The laboratory does best those tests which it does most frequently, and when tests are ordered infrequently, the quality of the results is apt to deteriorate. Routine panels of tests not only provide the physician with useful information about his patient, but also provide the laboratory with useful work in a volume which allows quality performance.

Advantages to the Patient

Although economic factors are most often mentioned in discussing panels of test programs, the most important reason for establishing panels of tests is the early recognition of unsuspected disease. Most physicians realize that many of their patients thought originally to have rheumatoid or osteoarthritis are found to have gout when the uric acid level is determined on the serum. Many patients have been found to have an elevated blood urea nitrogen which was unsuspected when the patient was admitted for elective surgery. Undiscovered diabetes which has gone undetected by routine urinalysis on early morning specimens is frequent-

ly discovered through postprandial blood sugar determinations. Also, many patients in congestive cardiac failure who have been on drugs such as digitalis and diuretics are found to have severely unbalanced electrolytes on admission to the hospital, conditions which would remain unsuspected if routine electrolytes were not done on medical patients. A patient undergoing surgery and on whom intravenous infusions are anticipated is surely protected when basic information on the serum sodium, potassium, chloride, carbon dioxide or pH is available to his physician, surgeon or anesthetist.

A patient often derives a feeling of confidence in knowing that in addition to the information his physician has gleaned by a thorough history and physical examination, more data will be available from places in his body the doctor cannot look at or into, feel, or hear, to help him arrive at a correct diagnosis and complete medical evaluation. This feeling of confidence will be even more pronounced if the intelligent and well-informed patient realizes that either the physical examination or the history, or both, have been performed in an abbreviated manner. In a rural community hospital without house staff, such routine panels of tests allow diagnosis and therapy to proceed at a much accelerated rate, which is often essential in caring for the severely ill patient, and particularly severely ill infants and children.

Preventive Medicine Concept

To accept routine laboratory procedures requires appreciation of the basic concept of preventive medicine, that it is more humane and economical to prevent or retard the develop-

ment of illness than it is to treat the patient after the disease has achieved full clinical dimensions. Numerous public health screening procedures by state health departments have brought to light many unsuspected cases of occult disease. For instance, new cases of diabetes have been found recently in every community in which this approach has been used in the state of New Hampshire.¹ During 40 days of operation, 11,006 persons were examined and 148 new diabetics (a yield of 1.3%) were found by using capillary blood samples and auto-analyzers. In Vermont, 247 cases of unsuspected diabetes were diagnosed in 9,500 persons screened in 1965.² But such programs are sporadic, at best. The continuing use of laboratory test panels allows a continuous preventive medical program to proceed in a setting ideally suited to provide quality performance indefinitely — the hospital laboratory. In addition such a program, once initiated, may also be extended to outpatients at the attending physicians' option.

Most objections to the panels of tests are based on the proposition that the cost of medical care is being increased, and this is simply an unnecessary economic burden to the average patient. However, it is not true that the bill will necessarily be higher, since the package price to the patient is considerably lower than if the same tests were ordered one by one, as indeed they frequently may be during the hospital stay. And while it is true that the episodic hospital bill may sometimes be larger, if one considers true economy to be the maintenance of a patient's productive capacity in society for the longest possible time, then a program which will help detect occult disease before it becomes crippling⁸ is inexpensive indeed.

Advantages to the Hospital Laboratory

The routine laboratory panel of tests alleviates some of the major problems in the small hospital laboratory where volume is apt to be low, since it becomes possible to establish a quality control program; it gives assurance that reagents will be used in such volumes as to guarantee that fresh materials are always on hand; it stabilizes the laboratory work load; and it makes it possible to plan the laboratory work day efficiently, since laboratory tests done in panels on admission often saves having to do them at add hours during the patient's hospital stay. A usually modest increase in total revenue to the laboratory due to larger volume makes it possible to maintain lower prices for many of those indispensable tests which are ordered infrequently (e.g., the thromboplastin generation test) but are inordinately expensive to perform. Furthermore, qualified personnel may be employed and up-to-date equipment may be acquired and maintained in good repair.

Panel Selection

The selection of a panel of tests sometimes presents a problem. It has been found that if the clinical pathologist suggests a list of automated laboratory tests to the members of the medical staff for their decision as to whether the tests meet the needs of their patients, a useful and inexpensive group of tests may be chosen. Without such co-operation between the clinical pathologist and the members of the medical staff, it is often difficult to achieve a worthwhile panel of tests.

The medical staff should also decide which patients are to receive a routine panel. It is possible to develop useful panels of tests for various categories of patients, such as those on medical, surgical, obstetrical and pediatric services. Often the addition of x-rays and electrocardiograms to

the panels is found to be helpful in protecting patients undergoing general anesthesia or major surgical procedures. These tests may be included in packages for selected categories of patients, particularly those in the older age groups.

Examples of the types of panel which can be drawn up are shown in the groups of tests which have been in effect in rural hospitals of 30 to 100 beds (Table 1).

Example of a laboratory requisition and report form now in use which includes three specific groups

of patients is shown in Table 2.

Panels of laboratory tests, when designed carefully in a co-operative venture between the patients' doctors and the pathologist laboratory director have much to add to preventive medical care in the small community hospital. Such panels will have usefulness in larger and more sophisticated medical communities as well, since the objectives of providing ever better medical care and high quality laboratory data at an economical rate for every patient are unquestionably related and desirable goals.

TYPES OF PANELS OF TESTS POSSIBLE IN THE SMALL HOSPITAL

<u>A*</u>	<u>B**</u>
<u>Surgical Patients</u>	<u>Pediatric Patients</u>
Urinalysis	Hemoglobin
Hemoglobin	Hematocrit
Hematocrit	White Blood Count
Erythrocyte Sedimentation Rate	Differential White
White Blood Cell Count	Blood Cell Count
Differential White Blood Count	Urinalysis
Serology (VDRL)	Reticulocyte Count
Partial Thromboplastin Time	Total Protein
Total Protein	Serum Sodium
Blood Glucose	Serum Potassium
Blood Urea Nitrogen	Throat Culture
Serum Sodium	
Serum Potassium	
Serum Chloride	
Blood Carbon Dioxide	

* The charge to the patient for Panel A could be one-half of the cost of the tests if ordered individually.

** The charge for Panel B could be less than one-third of the cost if each test were ordered separately.

TABLE 1

Summary

Laboratory panels of tests as an extension of the history, physical examination, urinalysis and blood count are a realistic approach to preventive medicine for the patient admitted to the hospital. Such panels benefit the patient in exposing occult disease and giving him a feeling of security in knowing that he has been adequately evaluated in many parameters while in the hospital, and has received a considerable amount of useful laboratory data at a low unit cost. It provides the smaller hospital in particular with laboratory revenue adequate enough to assure that quality work is performed by well trained, competent technologists on modern and well maintained equipment. The wisdom of cooperation between the medical staff and the clinical laboratory director is emphasized in the selection of panels of tests.

REFERENCES

1. Atchison, Mary M., personal communication.
2. Memorandum to Vermont Physicians, *Chronic Illness Division Bulletin*, State of Vermont Department of Health, April 13, 1966.
3. Collen, M.F.: Periodic Health Examination Using An Automated Multitest Laboratory, *JAMA* 195:142-145, March 7, 1966.
4. Editorial, "Routine Tests—The Physician's Responsibility," *New Eng. J. Med.* 274:222, January 27, 1966.
5. *Hospital Accreditation References*, American Hospital Association, Chicago, Illinois, 1961 Revision, p. 91.
6. *Ibid*, p. 34.
7. *Idem*.
8. Mayer, Jean: The Doctor's First Job—Preventing Sickness, *New York Times Magazine*, November 28, 1965. ▲

62 Elm Street
Lancaster, N.H. 03584

ADMISSION LABORATORY DATA

Time Drawn: _____ Date: _____

CHEMISTRY

Normal

M	Uric Acid	3-6	mg. % _____
PMS	Total Protein	6-8	gms. % _____
PMS	Micro-CO ₂	50-65	vol. % _____
PMS	Micro-Glucose	60-100	mg. % _____
PMS	Micro-BUN	8-20	mg. % _____
S	Sodium	136-145	meq./L. _____
S	Potassium	3.5-5.0	meq./L. _____
S	Chloride	100-106	meq./L. _____

Initials _____

HEMATOLOGY

Hemoglobin	12-16	gms. % _____
Hematocrit	40-50	% _____
E. S. R.	<15	mm/hr. _____
WBC	(5.-10) × 10 ³ /cmm.	_____

Differential:

Polys _____ Stabs _____ M _____ L _____ E _____

☐ M Prothrombin T. 100 _____ % _____

☐ S P. T. T. 40-100 sec. _____

VDRL (reported separately)

Initials _____

☐ PEDIATRIC PACKAGE: Micro-Glucose; Micro-BUN; Micro-CO₂; Total Protein; CBC.

☐ MEDICAL PACKAGE: Prothrombin Time; Uric Acid; Total Protein; Micro-CO₂; Micro-Glucose; Micro-BUN; CBC.

☐ SURGICAL PACKAGE: Total Protein; Micro-CO₂; Micro-Glucose; Micro-BUN; Na⁺; K⁺; Cl⁻; CBC; Partial Thromboplastin Time (PTT).

BLOOD BANK

☐ Blood Group and Type _____

☐ Cross Match _____ units
Initials _____

Name: _____
Address: _____
Physician: _____
Hosp. No.: _____

LABORATORY
ST. LOUIS HOSPITAL
BERLIN, N. H.

TABLE 2

What's all the fuss about bactericidal?

The ultimate aim in antibiotic therapy is to contain the bacterial colony and eliminate infection. Both 'cidal' agents and bacteriostatic DECLOMYCIN achieve this goal. DECLOMYCIN inhibits susceptible pathogens by stopping their growth; cidal agents affect the pathogens only while they are growing.

Though the two mechanisms differ, the end result is the same—containment of the infecting organism. *However, a very important attribute of any antibiotic is its potency against a broad range of pathogens.* DECLOMYCIN not only offers broad-spectrum potency, but high serum and tissue levels with persistent activity against tetracycline-sensitive organisms. Therapeutic benefits continue for 1-2 days after dosage stops to help prevent relapsing infection.

These are the reasons why so many doctors make DECLOMYCIN their basic broad-spectrum antibiotic. At last count, one billion doses had been administered since its introduction, and the number keeps rapidly growing.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE



Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

True broad spectrum

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanel has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

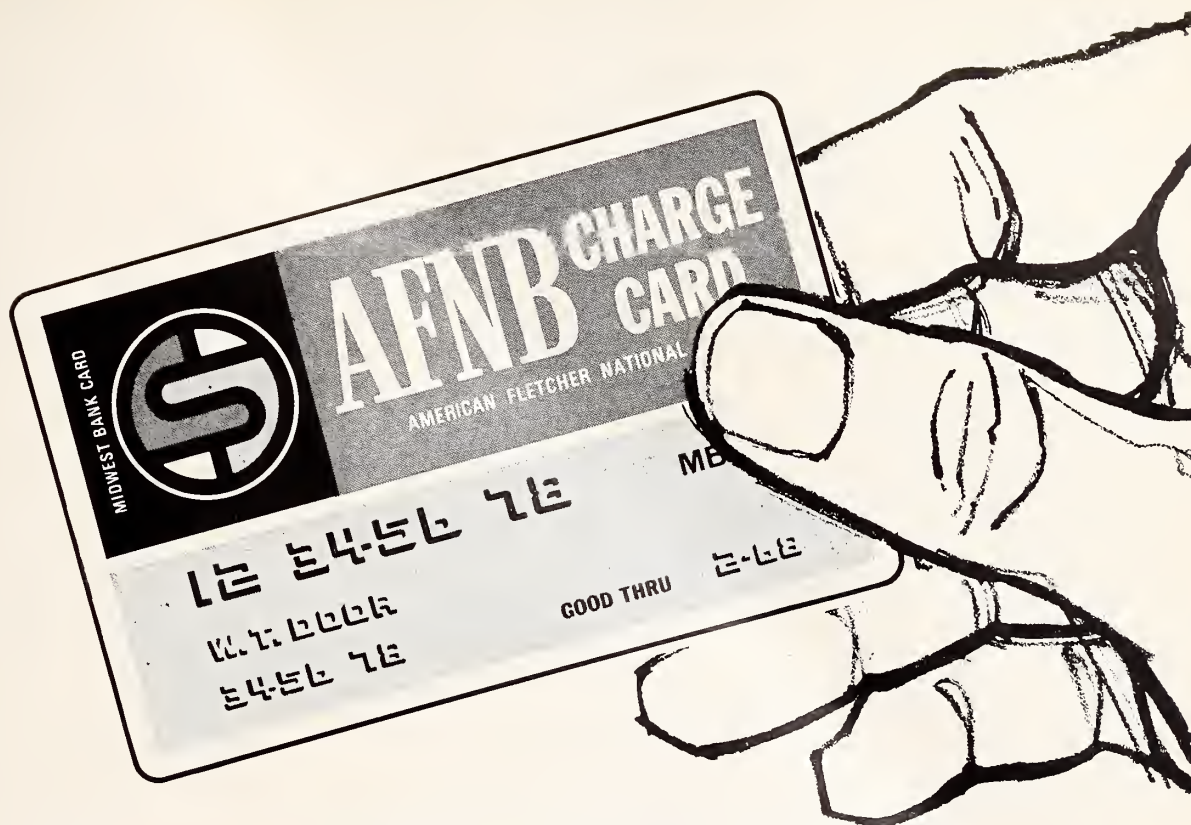
Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York





A CONVENIENCE FOR YOUR PATIENTS A BLESSING FOR YOU

By offering the AFNB Charge Card service you will provide many of your patients with the most convenient way to pay for your professional services. It will help you, too, by virtually eliminating your billing and collection duties . . . and your account is credited immediately when you deposit the daily charge tickets (which we provide). The AFNB Charge Card service can be offered by Physicians and Dentists within Marion County. Simply send the coupon or phone 633-2016 for complete information.

TO: AFNB Charge Card Division
101 Monument Circle
Indianapolis, Indiana 46209

I am interested in your program. You can call at my
office on _____ at _____
(DATE) (TIME)
or phone _____ for an appointment.
Name _____
Address _____

serving the professional man in a professional manner.



AFNB

AMERICAN FLETCHER NATIONAL BANK
INDIANAPOLIS, INDIANA MEMBER FEDERAL DEPOSIT INSURANCE CORPORATION

Comprehensive Health Planning and the Indiana University Medical Center

KENNETH E. PENROD, Provost
Indiana University Medical Center

IN a recent thought-provoking series of papers in *The New England Journal of Medicine** titled "Medicine, Money and Manpower — The Challenge to Professional Education," Dr. Ward Darley and Anne R. Somers have brought into focus what is, and what is not, being done to provide the nation's expanding population with an equally expanding health care service. If the goals are to be met, all facets of health care must be improved. In commenting on this point, the authors state: "Unless we can succeed in making better use of the resources we already have — not just money but brains, hands, technology, organizational and managerial skills and, above all, education — the American people most assuredly will not receive a fair return on the money being poured into the national medical establishment."

Many signs now point to a growing public demand for increased efficiency in hospitals, greater coordination and integration of health care facilities, and tangible evidence of concern for duplication and escalation of costs of health care. There is widespread feeling that more communication, greater areawide planning, coordination, and cooperation can result in significant economies and improvement of service.

In its proper role a state university medical center hospital should occupy a clearly defined niche within a statewide network of related facilities. Its resources should be equally available to all and, while its principal mandate is to provide a clinical teaching laboratory, by its very nature and breadth of resources, it must also

serve as a specialized unit for diagnosis and treatment.

Concentrated Cooperation

For such a unit to fit into a comprehensive picture, it must be planned and developed with full participation of representatives of collegial institutions. To this end, representatives of the state's medical, nursing and hospital associations, the Board of Health, Association of Private Clinics, Veterans Administration, Marion County Health and Hospital Corporation, Marion County Council, State Comprehensive Planning Commission and the State Budget Agency were invited to an open forum, held at the Indiana University Medical Center on July 13, with the architects and university medical center planners. This discussion centered around the design and functions of the new University Hospital and was the first in what is hoped will be a continuing series of meetings.

Not all of the above representatives were able to attend. Many of those who did expressed appreciation for an opportunity to become acquainted with this significant addition to the state's health care facilities at an early stage, as well as to participate in a general discussion of relationships among institutions. Some others who could not be present expressed interest and a desire for later involvement.

Following explanation of the physical design of the proposed facility, several of the medical center clinical faculty spoke briefly of their plans for the staffing and operation of departments. A worthwhile general discussion ensued on long-range coordinated planning for local, area and

state health care facilities and, in particular, the role of the university hospitals in the future.

Participation in Planning

Several recent developments of statewide significance underscore a need for reevaluation. The national program to combat heart disease, cancer, stroke, and related diseases, for which our state has been designated a planning region, is one. Another is provision of support by the 1967 General Assembly for a hospital-affiliated, internship-residency program and for telecommunication facilities which will link cooperating hospitals, as clinical teaching and training centers, into a statewide system of medical education with participation by practicing physicians throughout Indiana. Since the new hospital is to be part of that system, we cannot plan in a vacuum. We are seeking to anticipate future developments, and this requires participation in planning with other institutions and with professional associations that share responsibility for health care in the state.

The new University Hospital is being constructed as a replacement for the Robert W. Long Hospital, the first unit of which was constructed in 1914, and the William H. Coleman Hospital for Women, built in 1928. When completed about 1972, the new hospital will have approximately 800 beds and 58 bassinets. This hospital, along with the James Whitcomb Riley Hospital for Children, will serve as the clinical base for students in the schools of medicine and nursing, and the allied health programs. Present curricular plans call for the intro-

* Beginning June 1, 1967.

duction of each medical student to clinical medicine in this facility, followed by a wide range of opportunities for expanded clinical experiences at other hospitals located throughout the state.

Because of the size and cost of this structure, it is being constructed in units over a period of time. The first phase is now under construction and present plans call for occupancy during the summer of 1968; the unit will provide 246 beds. Planning and design are now under way, but still flexible, for the remaining portions of the hospital. Preliminary plans for the second unit have now been submitted for funding consideration to the Public Health Service and, assuming normal progress of both funding

and architectural design, construction should begin by late 1968. The state's portion of the cost of this unit was provided by the 1967 General Assembly. Funding for the third and final portion of this hospital will be requested from the 1969 General Assembly with construction to begin by late 1969 or 1970. The total cost of this facility is now estimated at approximately \$42 million.

It is significant that this will be the first hospital in the state to be designed from the start as primarily an instructional institution. Among the facilities, for example, will be extensive clinical and diagnostic laboratories, some for research or support of patient care and others for student use. Also included are specialized

intensive care units. The departments of the school of medicine are attempting to anticipate special teaching needs in their respective facilities, while planning together to insure maximum effectiveness in undergraduate, graduate, and continuing education programs.

It is the firm conviction of the planning and administrative staff of the Indiana University Medical Center that only such coordinated action as was begun by this meeting can bring the individual components of a statewide health care program to bear in the most economical, effective and expeditious manner. We welcome, indeed solicit, participation of colleagues. ◀

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis, Indiana 46208

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 9-12, Indianapolis, Indiana.

I propose to exhibit _____

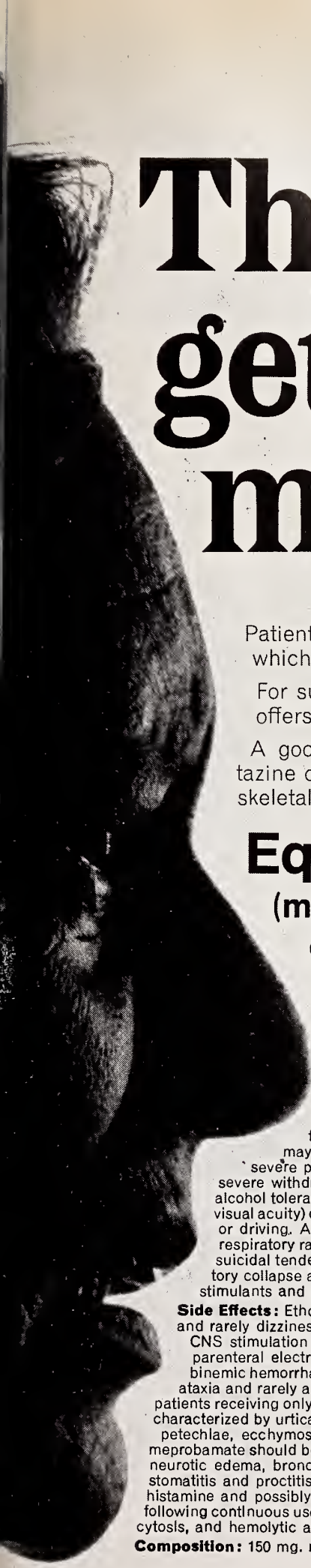
Name _____

Address _____

City _____

State _____





This pain is getting on my nerves.

Patients in pain often experience concomitant anxiety and tension, which may add to the burden of pain.

For such patients, you may want to prescribe a preparation that offers more than simple analgesia.

A good choice is often EQUAGESIC® (meprobamate and ethoheptazine citrate with aspirin). It helps relieve pain. And anxiety. And skeletal muscle spasm as related to pain or anxiety and tension.

Equagesic® TABLETS

(meprobamate and ethoheptazine
citrate with aspirin)



Contraindications: History of sensitivity or severe intolerance to aspirin or meprobamate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

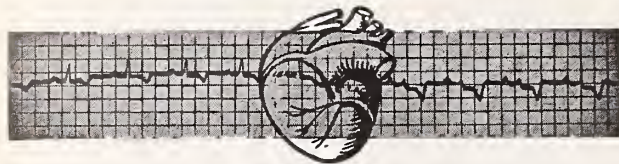
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate may result in dependence or habituation in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics. Withdraw gradually after prolonged high dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, caution patients against operating machinery or driving. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with immediate gastric lavage and appropriate supportive therapy (CNS stimulants and pressor amines as indicated).

Side Effects: Ethoheptazine and aspirin may occasionally cause nausea, vomiting, epigastric distress, and rarely dizziness. Overdosage may result in CNS depression (drowsiness and lightheadedness) or CNS stimulation and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]). Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angio-neurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically such as with epinephrine, antihistamine and possibly hydrocortisone. A few cases of leucopenia, usually transient, have been reported following continuous use. Rarely, cases of aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported; almost always, in the presence of known toxic agents.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Electrocardiogram of the month



Presented as a regular feature of *The JOURNAL*, *Electrocardiogram of the Month* is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Right Ventricular Hypertrophy (RVH) in Pulmonary Emphysema

CHARLES FISCH, M.D.
Indianapolis

As was pointed out earlier (ECG of the Month, May, 1967), the conventional pattern of RVH in V-1, namely rSr, rsR, RV-1/SV-1 >1, rR, R or qR is seen in less than 20% of patients with chronic obstructive pulmonary emphysema. This is thought to be due to the fact that RVH in emphysema does not attain the proportions seen in congenital heart disease or in cases of long-standing pulmonary hypertension.

An example of classical ECG change of RVH in a patient with severe pulmonary emphysema is presented in Figure 1. There is a normal S-A rhythm with a prolonged P-R interval (.28 sec.). The characteristic changes of P pulmonale, namely a P axis of +90 degrees with tall peaked P waves in leads II, III and AVF are present. There is an extreme

right axis deviation (about +240 degrees) of the QRS and clockwise rotation with prominent R in AVR, qR

in V-1 and R/S of 1 in V-6. The precordial QRS changes are characteristic of severe RVH. ◀

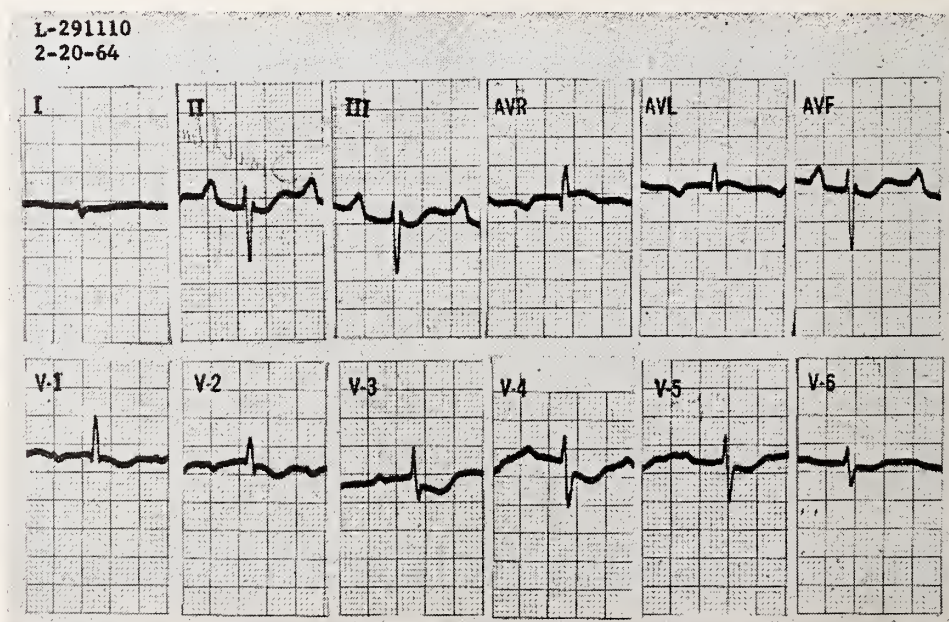


FIGURE 1
TRACING of pronounced right atrial and right ventricular hypertrophy in a patient with far advanced pulmonary emphysema (for details see text).

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Vesicorectal Fistula

ERICH K. LANG, M.D.
LAWRENCE ALLEN, M.D.
Indianapolis*

A 62-year-old white male was admitted to the hospital with a history of passage of air and fecal material during, and particularly at the end of, voiding. The patient related that for the past three months, the amounts of gas passed during voiding attempts had gradually increased. Fecal material had appeared in the urine in the last three weeks.

The past history was unremarkable and only upon suggestive questioning did the patient admit to a transient episode of left lower abdominal quadrant pain and intermittent bloody diarrhea some three years prior and again about six months ago. However, these symptoms subsided without specific treatment and the patient did not seek medical help for either episode.

Physical examination revealed considerable induration in the ischio-rectal fossa. Evacuation of discolored liquid from the rectum, conceivably urine, was noted. The anterior wall of the rectum appeared to be indurated and transfixed to the posterior bladder wall.

On basis of the characteristic clinical history, a vesicorectal or vesicocolonic fistula was suggested. Examination of the urine specimen readily revealed fecal material and vegetables fibers, confirming the pres-

ence of a communication between the bowel and the urinary-excretory system. A catheter specimen of both the right and left kidney urine demonstrated evidence of gross infection and inflammatory cells. Coliform bacteria were identified on direct smear.

A barium enema, utilizing a thin barium mixture, failed to reveal any

demonstrable fistulous tract between the colon and bladder, but ascertained the presence of diverticulosis and diverticulitis. A retrograde small bowel barium enema was performed two days later, attempting to demonstrate a fistulous connection. Even though multiple coned down lateral films of the pelvic inlet area were obtained

FIGURE 1

A ROENTGENOGRAM obtained during the voiding phase of cystogram demonstrates the fistulous communication between the bladder and the rectosigmoid. A massive amount of dye is seen in the rectum and rectosigmoid. The voiding phase is favored for optimal demonstration of such communications because of the advantageous pressure gradients created during the voiding act and because of the unique possibility of demonstrating low fistula between the bladder neck and posterior urethra, and the rectum.



* Radiologists, Methodist Hospital, Indianapolis 46207.

with meticulous care, no connection visualized.

An intravenous pyelogram showed blunting of the calices, suggestive of inflammatory manifestations, secondary to pyelonephritis. The bladder was only poorly opacified.

After meticulous preparation of the colon, a cystogram was performed (Figure 1). This time, the fistulous communication between the urinary bladder and the rectosigmoid was demonstrated without difficulty. The presence of diverticulosis and diverticulitis of the sigmoid colon suggested that abscess formation around the diverticula and fixation to the bladder resulted in the formation of the fistulous tract.

After broad spectrum antibiotic therapy for several days, a surgical resection of the fistulous tract was carried out, and both the bladder and

rectosigmoid were closed per primam.

Discussion

The demonstration of a fistula between the bladder and the large or small bowel often presents vexing problems. Even though the presence of a fistulous tract may be ascertained on basis of microscopic examination of the urine, the anatomical-topographical localization of the tract may meet with considerable difficulty. Barium enema, even contrast barium enemas, and small bowel barium enemas are frequently doomed to failure. Debris and the fluid dynamics creating a valve-like mechanism frequently preclude successful demonstration of a fistulous tract. However, thin aqueous contrast medium, injected into the urinary tract, will usually successfully delineate this communication.

In order of frequency, the following entities are listed as etiologic causes for the formation of such fistulous tracts: inflammatory disease, particularly diverticulitis and ileitis, neoplastic disease of either the bladder, cervix, uterus, or large bowel, particularly if treated by radical surgery and/or radiation therapy, generalized neoplastic disease and diverticula of the bladder. The most common fistulous communication is between the sigmoid colon or rectum and the bladder. However, communications to other segments of the colon and small bowel, particularly the terminal ileum, may be encountered. Fistula between the GI tract and the ureters, and even the female urethra as well as the kidney pelvis have been encountered in extensive neoplastic disease with necrosis of tissue. ◀

REGISTRATION FORM FOR ISMA ANNUAL CONVENTION GOLF TOURNAMENT

8:00 a.m., Tuesday, October 10, 1967, Speedway Golf Course, Indianapolis

Name_____

Address_____

City_____

State_____

Please indicate desired starting time_____

CLIP OUT AND MAIL TO:

B. A. Burkhardt, M.D.
202 S. West Street
Tipton, Indiana

Night Leg Cramps . . . Unwelcome Bedfellow In Diabetes¹, Arthritis², and Peripheral Vascular Disorders²

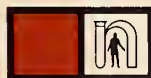


now . . . specific therapy for night leg cramps

Walker

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.



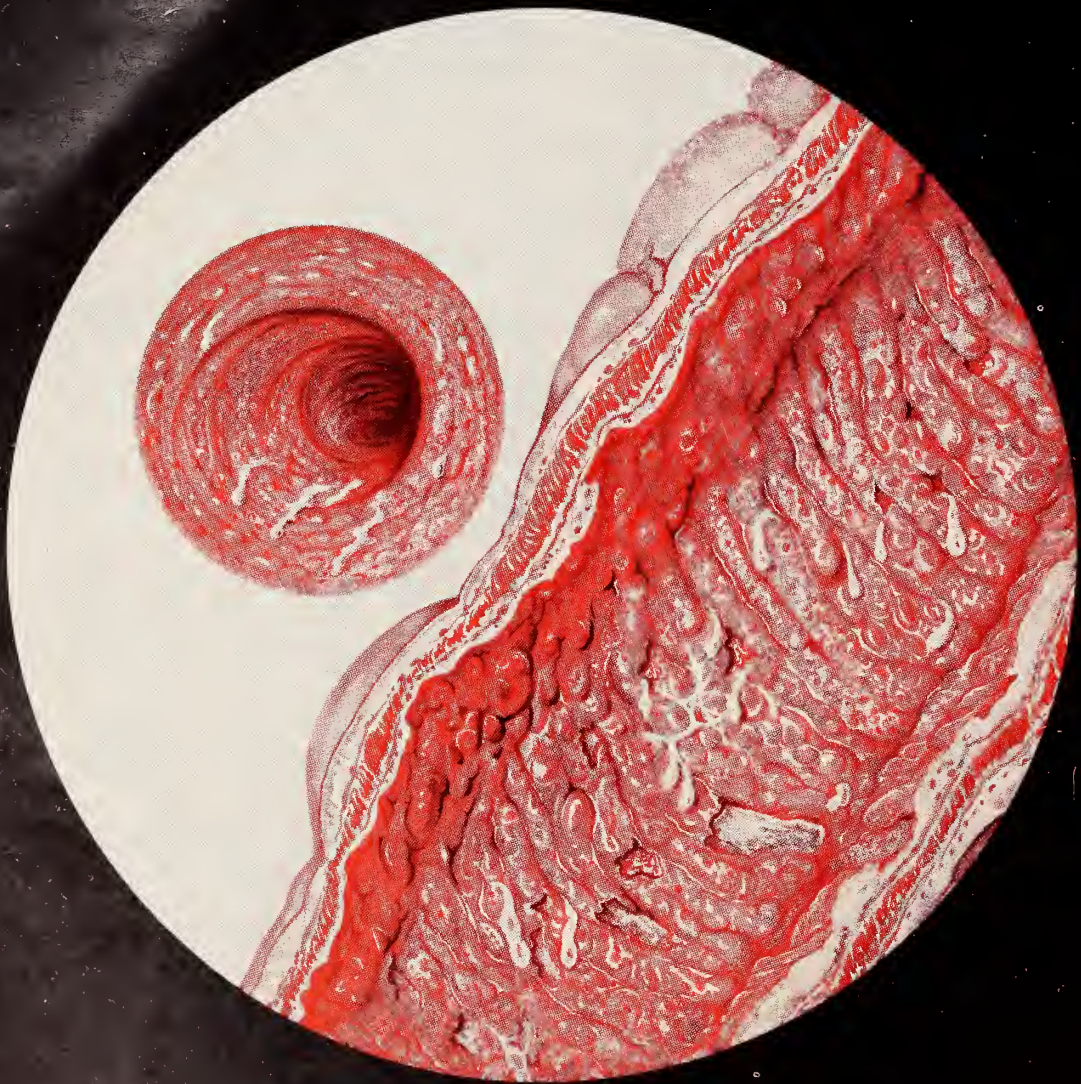
THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

even in ulcerative colitis...

characterized by:

- diarrhea, cramps, tenesmus
- bloody, mucoid, purulent stools



LOMOTIL[®] tablets/liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate 0.025 mg.









controls diarrhea

In six published studies¹⁻⁶ detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

*For correct therapeutic effect
Rx correct therapeutic dosage*

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . ½ tsp.*t.i.d. (3 mg.) 
6-12 mo. . . ½ tsp. q.i.d. (4 mg.) 
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.) 
2-5 yr. . . . 1 tsp. t.i.d. (6 mg.) 
5-8 yr. . . . 1 tsp. q.i.d. (8 mg.) 
8-12 yr. . . 1 tsp. 5 times daily (10 mg.) 
Adults: 2 tsp. 5 times daily (20 mg.) 
or 2 tablets q.i.d. 

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- Gastroenteritis
- Acute infections
- Spastic colon
- Drug induced diarrhea
- Functional hypermotility

exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. 180:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B., Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE Research in the Service of Medicine

A surrealist illustration of a man's back and shoulder. A large, detailed tree is tattooed onto the skin, with its roots spreading across the lower back and its branches reaching up towards the neck. The man's head is tilted back, and his neck is visible. The background features a landscape with trees and a body of water. The text "at the site of infection (where it counts)..." is written in the upper right corner.

at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food¹⁻³

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.^{1,2} Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.^{1,3}

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels

attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:

New! Ready-mixed Ilosone Liquid 125!
(Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

Ilosone®
Erythromycin Estolate



(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appears to be definitely related to use of the drug, laboratory findings are characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalofluorescent flocculation and thymol turbidity tests, elevated serum glutamic oxalacetic transaminase levels, peripheral eosinophilia, and abnormal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has been reported in other patients taking prolonged courses of medication. Patients with chronic infection have been given to 2 Gm. of the drug daily for periods of two to six months, patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of the patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who received 250 mg. of Ilosone daily for an average of sixteen months. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevations of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (3 to 10 day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticarial skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days is recommended. In the treatment of gonorrhea, patients with suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg. (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages. Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base) in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: *Am. J. M. Sc.*, 247:69, 1966. 2. Griffith, R. S., and Black, H. R.: *Antibiotics & Chemother.*, 12:398, 1966. 3. Hirsch, H. A., Pryles, C. V., and Finland, M.: *Am. J. M. Sc.*, 239:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46208.

Associate Editors: A. W. Cavins, M.D., 221 South Sixth
Street, Terre Haute; Lall G. Montgomery, M.D.,
Ball Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:

Term Expires

Harold D. Lynch, M.D., Evansville	Dec. 31, 1967
Jene R. Bennett, M.D., South Bend	Dec. 31, 1967
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickman, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Indiana 0 and 0

THE Indiana Academy of Ophthalmology and Otolaryngology celebrates the 50th anniversary of its founding this year.

In 1917, during the annual meeting of the Indiana State Medical Association, members of the Eye, Ear, Nose and Throat Section in attendance at the regular meeting, decided that they and other ophthalmologists and otolaryngologists of the state should meet more than once a year and that an independent society should be formed for this purpose. Dr. John R. Newcomb of Indianapolis was chosen as president and Dr. E. M. Shanklin of Hammond, secretary.

Permission was obtained from the state association to hold an interim meeting of the section for the purpose of organizing the new society. Accordingly in March of 1918 some 60 or 70 physicians, all specialists in ophthalmology and/or otolaryngology, met in Indianapolis, adopted a constitution and bylaws and founded the Indiana Academy of Ophthalmology and Otolaryngology. Fifty of this group are recorded as the founders.

The Golden Anniversary Meeting of the Academy was held in Indianapolis on May 11, 12 and 13 of this year. The meeting was honored by the presence of its only living found-

ing member, Dr. Joseph D. Heitger. Dr. Heitger, now of Louisville, practiced at Bedford until 1921, and although he has been incapacitated recently, is now recovering his health and plans to resume practice on a limited schedule, at the age of 85.

During the 50 years of its illustrious existence, the academy has listed on its role of officers many distinguished leaders of the two specialties in Indiana. It enjoys the distinction of being the oldest independent society of its nature in the United States. It embarks on its second 50 years with the applause and best wishes of the entire medical profession of the state.

Guest Editorials

The Myth of One-Unit Transfusions

IT has been asserted that when a patient has been given a transfusion of a single unit of blood and recovers, then the transfusion was probably unnecessary in the first place, because most patients requiring blood transfusions need at least two units of blood. This dictum fails to take into account differences among patients in size, age, weight, blood pressure, etc., and the elementary principle that when blood is administered to combat bleeding, the amount

to be administered should match the amount of blood lost. Since while a patient is losing blood there is no reliable way of determining ahead of time when the bleeding will stop, and for a small person with a low blood pressure a rapid loss of even so little as 500 ml. of blood may prove fatal, it is best to start the transfusion as soon as bleeding occurs during an operation, and at times even to anticipate blood loss, and then to terminate the transfusion when the bleeding is under control even if only one unit of blood has been given. To follow the dictum blindly and to administer more than one unit of blood when only one is needed may serve to overload a patient's circulation, and will in any event subject him to an increased risk of serum hepatitis, one of the calculated risks of blood transfusion.

As to be expected, lawyers have now taken advantage of the one-unit transfusion myth, and used it as a basis for lawsuits. In a recent case, a surgeon resected a tumor of the chest wall, and after about 400 cc. of blood had been lost, he ordered a blood transfusion which was started. When he later found that blood loss was not as great as anticipated (bleeding ended after no more than about 900 ml. of blood had been lost), and that

there was no longer any need for blood, the transfusion was terminated even though the patient had received only a single unit of blood. Six weeks later the patient developed severe jaundice, diagnosed as serum hepatitis, which was attributed to the blood transfusion he had been given at the operation. The patient then sued the surgeon on the ground that the surgeon had given an unnecessary blood transfusion, and thus negligently exposed him to the risk of serum hepatitis. This illustrates how the introduction of myths into medical practice interferes with the correct practice of medicine; and, in fact, may serve to penalize physicians who practice on the highest plane. The myth of one-unit blood transfusions has taken such a firm hold that hospitals in which an "excessive number" of one-unit transfusions have been given have been threatened with loss of their accreditation.

If a blood transfusion is felt to have been unnecessary, the way to determine whether this may be so is by scrutinizing the *indications* used for the transfusion and not merely by

inquiring as to the *volume* of blood transfused. *The dictum regarding one-unit transfusions is obviously nothing but arm-chair philosophy, and bears no relation at all to the daily practice of medicine.*—**Alexander S. Weiner, M.D., Brooklyn, N. Y., Bulletin of the Medical Society of the County of Kings and The Academy of Medicine of Brooklyn, Inc., 46:4, April, 1967. Reprinted with permission.**

Editorial Notes...

A pilot plant for irradiating tropical fruits to overcome quarantine barriers and facilitate marketing in the mainland has been opened in Honolulu. Powered by 250,000 curies of cobalt 60, the facility is expected to prolong the "keeping" qualities of fresh fruits sufficiently to allow for economical surface transportation to the mainland as opposed to current air shipment. Certain fruits, presently quarantined from the mainland because of infestation by the Hawaiian fruit

fly and the mangoe seed weevil, will be processed with radiation to overcome this import restriction. If successful, the mainland market for Hawaiian papaya could jump from five million to 45 million pounds annually by 1980.

The Public Health Service has awarded 17 research grants totaling \$784,000 for the development of methods of disposal of solid wastes. Emphasis will be on conversion of wastes to useful foods and chemicals. One of the new projects is research by a University of Florida scientist who is seeking a procedure for converting citrus fruit wastes into citric acid, which is used in U. S. industry in the amount of about 100 million pounds a year. More mundane projects include control of livestock feedlot odors (big barn smell into little barn smell) and a grant of \$56,572 to Purdue University to develop a complete digestion system for cattle waste disposal.

The Public Health Service is publishing a new journal — Pesticides Monitoring Journal — Volume 1, Number 1, of which appeared in June. In 1961 the Secretaries of Defense, Interior, Agriculture, and Health, Education and Welfare formed the Federal Pest Control Review Board. In 1964, the board was reorganized as the Federal Committee on Pest Control. This committee now has a subcommittee on pesticide monitoring. A continuing network has been developed to monitor residue levels of pesticides in the air, water, soil, man, wildlife and fish. The first issue is devoted to a description of the monitoring program. One of its appendices lists 54 commonly used chemicals for which residue data are sought, mostly in foodstuffs.

Eli Lilly and Company will issue seven commemorative medals to honor the pioneer in-

Billsbord

WANTED: A physician between the ages of forty-one and fifty-three with some teaching experience. He must never, at least since student or intern days, have delivered a baby, performed an appendectomy or a tonsillectomy, nor been a member of a surgical team. He must never have had sole medical responsibility for a sick child, a sick adolescent, a sick adult, or a sick senescent person. He must never have administered an anesthetic, interpreted an x-ray film, nor made a microscopic diagnosis on a surgical specimen. He must never have faced the disheartening experience of informing parents that their child is retarded, nor a young husband that his wife has Hodgkin's disease. He must never have faced the distressful challenge of care of a patient with terminal cancer or with a chronic neurologic disease.

For any physician meeting the above requirements there is an unique administrative and investigative position as a participant in the development and execution of a nationwide program designed to evaluate the quality of medical care rendered the people of this country by its practicing physicians. —**William R. Carson, M. D., New York State Journal of Medicine, p. 1211, May 1, 1967. Reprinted with permission.**

investigators of infectious diseases. Antonj van Leeuwenhoek, the first microscopist, will be the subject of the first medal. The series will be concluded with a medal honoring Sir Alexander Fleming.

Farm accidents disable three quarters of a million people annually. And victims of farm accidents have a disproportionately high death rate. Only those employed in mining and construction have higher accident and death rates. One and one-half times as many people are injured in traffic accidents in rural counties as are in urban accidents. Rural traffic accidents also cause almost four times as many fatalities as do urban accidents. The AMA Council on Rural Health is developing a program to improve emergency medical services in rural areas. Two improvements sought are better first aid care and safer transportation to the hospital.

The effect of oral contraceptives on the metabolism of young, middle-aged and older women will be studied by the Alexander Simpson Laboratory for Metabolic Research at St. Mary's Hospital Medical School, London, England, as a result of a grant of \$43,120 from the National Institute of Child Health and Human Development of Bethesda, Maryland. Carbohydrate, intermediary and lipid metabolism will be investigated to determine whether detrimental effects are produced by the contraceptive hormones.

Hearing conservation programs may be ineffective because of inaccurate audiometers. The National Center for Chronic Disease Control reports that a three-year evaluation program by a university calibration center revealed many instruments with significant variations. The 100 audiometers tested in the three-year program will now be

followed to determine how often recalibration is necessary. A self-calibrating audiometer is being sought—all models now in use are apparently subject to loss of validity.

A poisonous spider, "The Brown Recluse", an inhabitant of the southern states, is reported to be moving north and may be found in Indiana. The Brown Recluse is more dangerous than the Black Widow, and unlike the outdoors-living Widow, favors the house and hides in clothing and bedclothes. It bites usually in self-defense. The bite is not immediately painful and sometimes is not recognized. The bite site, however, may slough enough to require skin graft. Fatalities are reported. The Brown Recluse is about one-half inch long and is distinguished by an almost perfect violin shaped marking on the back in brown or yellowish-brown. *Health Insurance News* warns that localized necrosis of the skin may be due to a Brown Recluse bite which was not recognized at the time. ◀

About Our Cover

A man of distinction proudly wears the badge featured on this month's cover.

It is his ticket to learning, entertainment and friendship.

Where else can you get so much for so little?

This issue of *The Journal* brings you the complete program and reports of officers. With it you can plan the programs you wish to attend and also get a preview of the scientific and technical exhibits.

Back this year will be the golf tournament, the trap and skeet shoot and the art and hobby show. Everything has been planned for your enjoyment, relaxation, enlightenment and entertainment.

In addition, you may plan to attend the Fireside Conferences; general scientific and section meetings; elections of section officers; past president's luncheon; women physicians' dinner meeting; reception and luncheon for members of the Fifty-Year Club; the president's luncheon; educational movies and the Gaslight Party — back by popular demand.

Don't miss it — it gets bigger and better each year!—J.F.S.

President's Page

Dear Doctor:

As you must know from this issue, the annual meeting of the Indiana State Medical Association will be held October 9, 10, 11 and 12. This brings us to the urgent need for you to express your complaints, your compliments and your ideas to the delegates from your county. These men can carry to the convention the opinions of their constituency only if these opinions are made known to them.



Many of you, I am quite sure, have strong convictions concerning many different problems that face medicine in Indiana today. I would urge you to come before the reference committees that will be meeting during the convention, and voice your opinion. Here you can present your ideas to men who are going to write policy into the Indiana State Medical Association. Here you can see to it that succeeding presidents and councils do your bidding. Perhaps after hearing testimony at a reference committee, your opinion might be changed. Perhaps your opinion might be confirmed. Nevertheless, your opinion is urgently needed.

We think we have a good program for this meeting — for both you and your wife. The Gaslight Party will be held again this year.

Now, doctor, where else can you go where you can express your opinions on medicine and be heard, or express your disgust and disillusion with organized medicine to the very people that formulate policy? And hear good scientific lectures that would help you in your practice, have a good time and spend only four days? I believe this is a bargain that few of us can afford to miss. Like all presidents, I would like to see the number of people present at the convention increase over previous years. However, I would much rather see the physician participation in his own organization increase many fold. Why not spend a few days at the convention? I'll be looking for you.

Eugene S. Rifkin M.D.

Eczema of many years... controlled in two weeks



Before treatment



After treatment —
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side

effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive non-permeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIEMAN, M.D.

Aristocort®

Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-B

The Woman's Auxiliary

REPORTS TO ISMA

Summer is the time for all county auxiliaries to formulate plans for the fall, winter and spring. The Indiana State Medical Auxiliary is no exception: we too have been busy laying the groundwork for the year.

The executive committee of the state auxiliary met July 18th in the ISMA Building. Plans were made for the State Workshop which will be held September 20th at Indiana Central College, Indianapolis. It is at this workshop county officers and chairmen can get practical information as well as inspiration from the state officers and chairmen who conduct the meeting. This is a fun day too, for it gives us the opportunity to visit with the ladies of other auxiliaries. However we too have the problem that besets all organizations — these workshops are not as well attended as they should be.



In Indiana we have 56 organized auxiliaries. Each auxiliary should send at least one representative to the workshop: larger auxiliaries send 4-10 persons. Approximately 30 ladies assist in presenting the workshop program and yet we are fortunate if we have a total registration of 70. This year, (in an effort to create more interest), I plan to send personal hand-

written invitations to all county presidents, as well as the printed information that is usually mailed.

There are other sources of information available to the auxiliaries. *M.D.'s Wife* (a national publication) and *Hoosier Doctor's Wife* (a state publication) are mailed to all auxiliary members. Our state program book and *The Direct Line* (national publication) are mailed to all state officers, chairmen, county presidents and presidents-elect.

Dr. Eugene Rifner and Dr. G. O. Larson both sent messages to be printed in our program book. We are happy for this contribution from the leadership of the ISMA.

We are again approaching the time when we will be seeking a renewal in membership and inviting non-members to join our auxiliaries. Dr. Milford O. Rouse, AMA President, has asked the national auxiliary to increase its membership of almost 90,000 by 10,000. Indiana must do its share in this effort. Will you please help by encouraging your wives to become active members in their local auxiliary?

Roberta P. Deever

Coming home is wonderful

when you have Blue Cross - Blue Shield

When you've got your girl home from the hospital, and the money you'd been saving for "something special" is still intact—that's a wonderful day. Blue Cross and Blue Shield are specialists in furnishing worry free health care protection. Their sole function is to help members pay their hospital and doctor bills. And these days, when the cost of quality, life-saving health care is rising, Blue Cross-

Blue Shield is more necessary than ever. About 1,700,000 Hoosiers—one out of every three persons in Indiana—belong to this trusted health care plan. Some 10,000 groups—the largest and the smallest employers in the state—believe in Blue Cross-Blue Shield's efficient, no-red-tape kind of operation.

Blue Cross-Blue Shield's success is measured not in earnings but in benefits provided its members.

That's why so many people—particularly at homecomings—are likely to say: "I don't know what we would have done without Blue Cross-Blue Shield."



Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series of ads
being run in key
Hoosier newspapers)

Move to leadership One of the many reasons Indiana National Bank is the leader in providing trust services is because of the expertise of its staff . . . specialists in trust and estate administration, investment management, pension and profit sharing trusts, taxes, and property management. We invite your inquiries into our full range of corporate and personal financial planning services.

TRUST DEPARTMENT / THE INDIANA NATIONAL BANK
OF INDIANAPOLIS



118th
Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 9, 10, 11 and 12, 1967

All Events on Eastern Standard Time

Murat Temple, Indianapolis, Indiana

*Complete Program and
Annual Reports on
Following Pages*

CONVENTION SECTION

Table of Contents

CONVENTION ISSUE (begins)	1201	Eighth Councilor District	1228
OFFICIAL CALL TO THE HOUSE OF DELEGATES	1203	Ninth Councilor District	1228
HOUSE OF DELEGATES	1204	Tenth Councilor District	1228
1966-67 ISMA OFFICERS	1207	Eleventh Councilor District (no report)	
Past Presidents	1207	Twelfth Councilor District	1229
Officers	1207	Thirteenth Councilor District	1229
Councilors	1207	Editor of The Journal	1229
Delegates to AMA	1207	Delegates to AMA	1230
50-YEAR CLUB, 1967	1207	REPORTS OF COMMITTEES	
OFFICERS OF THE ISMA	1208	Executive	1235
The Journal	1210	Medical Defense	1236
Section Officers	1211	Membership Report	1236
PROGRAM FOR THE 118th ANNUAL		The Journal Advertising	1237
ISMA CONVENTION	1215	Grievance	1237
Auxiliary Program	1222	Student Loan	1238
CONVENTION ARRANGEMENTS COMMITTEES	1222	Future Planning	1238
REFERENCE COMMITTEES	1222	Medical-Legal Review (no report)	
REPORTS OF OFFICERS	1223	Building (no report)	
Executive Secretary	1223	REPORTS OF COMMISSIONS	
Treasurer	1227	Constitution and Bylaws	1240
Chairman of the Council (no report)		Legislation	1240
District Councilors		Public Information (no report)	
First Councilor District	1227	Governmental Medical Services (no report)	
Second Councilor District (no report)		Public Health	1241
Third Councilor District	1227	Voluntary Health	1242
Fourth Councilor District (no report)		Medical Economics and Insurance	1244
Fifth Councilor District (no report)		Inter-Professional Relations	1244
Sixth Councilor District	1227	Medical Education and Licensure	1245
Seventh Councilor District	1228	Special Activities	1245
		Aging	1249
		RESOLUTIONS	1250
		EDUCATIONAL FILMS	1250
		SCIENTIFIC EXHIBITS	1251
		TECHNICAL EXHIBITORS	1255

Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 9, 10, 11 and 12, 1967.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, nine delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union county societies, each two delegates; the other 58 county societies, each one delegate; 13 councilors, and the ex-presidents, namely, F. S. Crockett, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black and Kenneth O. Neumann, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 2:00 p.m., Monday, October 9, 1967, in the Ballroom, Columbia Club, and again at 9:00 a.m., Thursday, October 12, 1967, in the Ballroom, Columbia Club.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Tribute to members of House who have died since the 1966 session.
5. Reading of the minutes of previous meetings.
6. Introduction of guests.
7. Appointment of Reference Committees and assignment of meeting rooms.
8. Unfinished business.
9. Address of president-elect.
10. Report of president of the Woman's Auxiliary.
11. Report of Indiana Chapter Student A.M.A.
12. Report by president of Blue Shield.
13. Report of executive secretary.
14. Report of treasurer.

15. Report of the chairman of the Council.
16. Reports of councilors.
17. Report of *Journal* editor.
18. AMA Delegates' report.
19. Report of State Board of Medical Registration and Examination.
20. Reports of committees and commissions.

COMMITTEES:

- (1) Executive
- (2) Grievance
- (3) Student Loan
- (4) Medical-Legal Review
- (5) Building
- (6) Future Planning

COMMISSIONS:

- (1) Convention Arrangements
 - (2) Constitution and Bylaws
 - (3) Legislation
 - (4) Public Information
 - (5) Governmental Medical Services
 - (6) Public Health
 - (7) Voluntary Health Agencies
 - (8) Inter-Professional Relations
 - (9) Medical Economics and Insurance
 - (10) Medical Education and Licensure
 - (11) Special Activities
 - (12) Aging
21. New Business
 - (1) Resolutions

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1967, and their successors must be elected at the session: delegates to the American Medical Association to succeed Guy A. Owsley, Hartford City and Jack E. Shields, Brownstown; alternate delegates to succeed Maurice E. Glock, Fort Wayne and Dwight W. Schuster, Indianapolis.

Delegates from the Third, Sixth, Ninth and Twelfth Districts are reminded that the terms of their councilors will expire October 12, 1967, and new councilors should be elected to succeed the following:

Third District — Donald M. Kerr, Bedford

Sixth District — William R. Tindall, Shelbyville

Ninth District — Peter R. Petrich, Attica

Twelfth District — Milton F. Popp, Fort Wayne

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

HOUSE OF DELEGATES

Indiana State Medical Association

Indianapolis—October 9, 10, 11 and 12, 1967

County and Delegates	Alternates	County and Delegates	Alternates
ADAMS (1)		DE KALB (1)	
Norman E. Beaver, Berne	Norval Rich, Decatur	E. E. Rogers, Auburn	Charles Weirich, Butler
ALLEN (6)		DELAWARE-BLACKFORD (3)	
Jerald L. Andrew, Fort Wayne	Fred W. Dahling, New Haven	Glynn Rivers, Muncie	Ross Egger, Middletown
W. Lloyd Bridges, Fort Wayne	Kenneth W. Klooze, Fort Wayne	Thomas M. Brown, Muncie	Clyde Botkin, Muncie
John S. Farquhar, Fort Wayne	William C. Ashman, Fort Wayne	Dean B. Jackson, Hartford City	Richard Ingram, Montpelier
Charles H. Aust, Fort Wayne	Herbert K. Acker, Fort Wayne		
Richard B. Juergens, Fort Wayne	James P. Scudder, Fort Wayne		
Edwin E. Stumpf, New Haven	Kenneth F. Isenogle, Fort Wayne	DUBOIS (1)	
		Thomas H. Gootee, Jasper	John Barrow, Dale
BARTHOLOMEW-BROWN (2)		ELKHART (2)	
		Thomas A. Elliott, Elkhart	Patrick Campbell, Elkhart
BENTON (1)		James D. Finfrock, Elkhart	James Miller, Wakarusa
Robert H. Leak, Boswell	Thomas J. Stoltz, West Lafayette		
BOONE (1)		FAYETTE-FRANKLIN (2)	
		William F. Kerrigan, Connersville	A. M. Hudson, Connersville
CARROLL (1)		Perry Seal, Brookville	H. N. Smith, Brookville
T. Neal Petry, Delphi		FLOYD (1)	
CASS (1)		Irvin H. Sonne, New Albany	Everett E. Bickers, New Albany
Donald K. Winter, Logansport	R. H. Maschmeyer, Logansport	FOUNTAIN-WARREN (2)	
CLARK (1)		Max Hoffman, Covington	Lowell Stephens, Covington
Eli Goodman, Charlestown		William Ringer, Williamsport	Carl Nelson, West Lebanon
CLAY (1)		FULTON (1)	
Rahim Farid, Brazil		Dean K. Stinson, Rochester	K. K. Kraning, Kewanna
CLINTON (1)		GIBSON (1)	
Robert Hedgcock, Frankfort		Virgil McCarty, Princeton	William E. Dye, Oakland City
DAVIESS-MARTIN (2)		GRANT (1)	
Robert H. Rang, Washington	C. Philip Fox, Washington	Robert M. Brown, Marion	Lester L. Renbarger, Marion
E. B. Lett, Loogootee	R. E. Chattin, Loogootee	GREENE (1)	
DEARBORN-OHIO (2)		Sam Rotman, Jasonville	H. B. Turner, Bloomfield
Leslie M. Baker, Aurora	Frank L. Frable, Lawrenceburg	HAMILTON (1)	
Gordon S. Fessler, Rising Sun	Amado S. A. Mauricio, Rising Sun	Joe R. Lloyd, Noblesville	Adrian Lanning, Noblesville
DECATUR (1)		HANCOCK (1)	
William Shaffer, Greensburg		Wayne H. Endicott, Greenfield	Bob R. Cagle, New Palestine

County and Delegates	Alternates	County and Delegates	Alternates
HARRISON-CRAWFORD (2)		LAWRENCE (1)	
W. J. Brockman, Corydon	Carl Dillman, Corydon	Joseph Dusard, Bedford	Glen D. Ley, Bedford
Jesse Benz, Marengo		MADISON (2)	
HENDRICKS (1)		Robert D. Williams, Markleville	W. L. Patterson, Anderson
Malcolm O. Scamahorn, Pittsboro	Elmer Koch, Danville	Paul T. Lamey, Anderson	Horace Jones, Anderson
HENRY (1)		MARION (21)	
Kenneth Hill, New Castle	David R. Cain, New Castle	James H. Gosman, Indianapolis	John W. Beeler, Indianapolis
HOWARD (1)		Dwight W. Schuster, Indianapolis	William M. Walton, Indianapolis
Warren McClure, Kokomo	Richard Halfast, Kokomo	James M. Leffel, Indianapolis	Robert B. Chevalier, Indianapolis
HUNTINGTON (1)		Donald E. Wood, Indianapolis	Frank W. Countryman, Indianapolis
Richard Wagner, Huntington	Reeve B. Peare, Huntington	Albert M. Donato, Indianapolis	Robert D. Arnold, Indianapolis
JACKSON-JENNINGS (2)		Morris E. Thomas, Indianapolis	Robert L. Gregory, Indianapolis
Harry Baxter, Seymour	William Scharbrough, Ewing	Joseph C. Finneran, Indianapolis	Marvin C. Christie, Indianapolis
Forrest D. Ellis, North Vernon	William Johnson, North Vernon	Myron H. Nourse, Indianapolis	Berj Antreasian, Indianapolis
JASPER (1)		Donald E. Stephens, Indianapolis	Austin L. Gardner, Indianapolis
Kenneth R. Ockermann, Rensselaer		Joseph L. Haymond, Indianapolis	Carroll Hasewinkel, Indianapolis
JAY (1)		Jack W. Hickman, Indianapolis	Edwin S. McClain, Indianapolis
JEFFERSON-SWITZERLAND (2)		William A. Karsell, Indianapolis	Dennis Nicholas, Indianapolis
Robert O. Zink, Madison	Robert Johnson, Madison	Thomas E. Lunsford, Indianapolis	John S. Schechter, Indianapolis
Noel Graves, Vevay		Louis W. Nie, Indianapolis	Richard A. Brickley, Indianapolis
JOHNSON (1)		Hunter A. Soper, Indianapolis	W. Stanley Garner, Indianapolis
Joseph W. Young, Greenwood	Charles A. Jones, Franklin	Charles E. Test, Indianapolis	John D. Graham, Indianapolis
KNOX (1)		Malcolm L. Wrege, Indianapolis	Kenneth L. Gray, Indianapolis
Herbert O. Chattin, Vincennes		F. Robert Brueckmann, Indianapolis	M. Richard Harding, Indianapolis
KOSCIUSKO (1)		Donald H. McCartney, Indianapolis	Robert F. Nagan, Indianapolis
William Cron, Warsaw		Ronald H. Hull, Indianapolis	Henry G. Nester, Indianapolis
LA GRANGE (1)		William B. Lybrook, Indianapolis	Fred L. Toumey, Indianapolis
Philip E. Yunker, Howe	Dean Mattox, Howe	MARSHALL (1)	
LAKE (9)		Robert G. Reed, Plymouth	
Nicholas Egnatz, Hammond	R. A. Church, Munster	MIAMI (1)	
T. C. Tyrrell, Calumet City, Ill.	R. M. Madlang, Munster	Lloyd Hill, Peru	
Philip J. Rosenbloom, Gary	J. J. Sala, Gary	MONTGOMERY (1)	
George Thegze, East Chicago	R. J. Purcell, Griffith	Richard Eggers, Crawfordsville	J. M. Kirtley, Crawfordsville
Jacob Pruitt, Gary	C. T. Disney, Gary	MORGAN (1)	
John Brincko, Gary	Walfred Nelson, Gary	Jay S. Reese, Martinsville	
Seymour Shapiro, Gary	E. A. Campagna, East Chicago	NEWTON (1)	
David Templin, Lowell	W. J. Fitzpatrick, Munster	Arthur Schoonveld, Brook	Marc Guzman, Morocco
V. J. Santare, Munster		NOBLE (1)	
LA PORTE (2)		Robert E. Bryan, Kendallville	Donald J. Hooker, Ligonier
J. C. Richter, Michigan City	E. C. Mueller, LaPorte	ORANGE (1)	
T. D. Armstrong, Michigan City	Frank McGue, Michigan City	P. T. Hodgin, Orleans	Marion L. Hagan, French Lick
		OWEN-MONROE (2)	

County and Delegates	Alternates	County and Delegates	Alternates
PARKE-VERMILLION (2)		STARKE (1)	
W. D. Britton, Montezuma	M. O. Beebe, Rockville	Guy B. Ingwell, Knox	Clark McClure, Knox
Milton Herzberg, Clinton	J. W. Somerville, Clinton	STEUBEN (1)	
PERRY (1)		John J. Hartman, Angola	Claude Davis, Angola
Fred Smith, Tell City	Robert A. Ward, Tell City	SULLIVAN (1)	
PIKE (1)		Joe Dukes, Dugger	J. H. Crowder, Sullivan
Milton Omstead, Petersburg		TIPPECANOE (2)	
PORTER (1)		Ramon Dubois, Lafayette	W. R. VanDenBosch, Lafayette
POSEY (1)		Forrest J. Babb, Stockwell	William E. Bayley, Lafayette
John Vogel, Mt. Vernon	John Crist, Mt. Vernon	TIPTON (1)	
PULASKI (1)		Albert E. Stouder, Kempton	Boyd A. Burkhardt, Tipton
William R. Thompson, Winamac	E. L. Hollenberg, Winamac	VANDERBURGH (5)	
PUTNAM (1)		George W. Willison, Evansville	Joseph E. Coleman, Evansville
John Ellett, Coatesville	James B. Johnson, Greencastle	John D. Wilson, Evansville	H. Jerome Rietman, Evansville
RANDOLPH (1)		Ray H. Burnikel, Evansville	Robert H. Oswald, Evansville
Lowell W. Painter, Winchester	B. D. Wagoner, Union City	A. Wayne Ratcliffe, Evansville	Albert S. Ritz, Evansville
RIPLEY (1)		James H. Crawford, Evansville	William C. H. Grimm, Evansville
Bill E. Freeland, Batesville	Lloyd W. Hisrich, Batesville	VIGO (2)	
RUSH (1)		Thomas J. Conway, Terre Haute	Norman Silverman, Terre Haute
Frank H. Green, Rushville		William G. Bannon, Terre Haute	Fred Dierdorf, Terre Haute
ST. JOSEPH (5)		WABASH (1)	
W. Robert Orr, Mishawaka	R. A. Ganser, Mishawaka	Fred Poehler, LaFontaine	
Louis F. Sandock, South Bend	John Neher, South Bend	WARRICK (1)	
S. E. Bechtold, South Bend	G. M. Haley, South Bend	Wendell Stover, Boonville	Noel J. Martin, Boonville
Jacob Rosenwasser, Mishawaka	H. A. Schiller, South Bend	WASHINGTON (1)	
W. J. Stogdill, South Bend	Donald G. White, South Bend	WAYNE-UNION (2)	
SCOTT (1)		Glen Ward Lee, Richmond	Tom Shields, Richmond
Marvin McClain, Scottsburg	Thomas Neathamer, Scottsburg	James F. Lewis, Liberty	William B. McWilliams, Liberty
SHELBY (1)		WELLS (1)	
Wilson L. Dalton, Shelbyville	John A. Davis, Flat Rock	Truman E. Caylor, Bluffton	David G. Pietz, Bluffton
SPENCER (1)		WHITE (1)	
Michael O. Monar, Rockport		Martin Dickerson, Monticello	
		WHITLEY (1)	
		Thomas G. Hamilton, Columbia City	Frank Thompson, Columbia City

PAST PRESIDENTS

Franklin S. Crockett, West Lafayette
Herman M. Baker, Evansville
Karl R. Ruddell, Indianapolis
M. A. Austin, Evansville
Paul D. Crimm, Evansville
William H. Howard, Hammond
W. U. Kennedy, New Castle
M. C. Topping, Terre Haute
Kenneth L. Olson, South Bend
Earl W. Mericle, Indianapolis
Guy A. Owsley, Hartford City
Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis
Joseph M. Black, Seymour
Kenneth O. Neumann, Lafayette

OFFICERS

President—Eugene S. Rifner, Van Buren
President-elect—G. O. Larson, LaPorte
Chairman, Executive Committee—
Ralph V. Everly, Indianapolis
Member, Executive Committee—
Burton E. Kintner, Elkhart
Treasurer—Ottis N. Olvey, Indianapolis
Assistant Treasurer—Lester H. Hoyt,
Indianapolis

Chairman of the Council—Lowell H. Steen,
Whiting
Editor—Frank B. Ramsey, Indianapolis
Executive Secretary—James A. Waggener,
Indianapolis

COUNCILORS

1st District—P. J. V. Corcoran, Evansville
2nd District—Joe Dukes, Dugger
3rd District—Donald M. Kerr, Bedford
4th District—Robert M. Reid, Columbus
5th District—Wilbert McIntosh, Riley
6th District—William R. Tindall,
Shelbyville
7th District—Albert M. Donato,
Indianapolis
8th District—Donald R. Taylor, Muncie
9th District—Peter R. Petrich, Attica
10th District—Lowell H. Steen, Whiting
11th District—Lowell J. Hillis, Logansport
12th District—Milton F. Popp, Fort Wayne
13th District—Otis R. Bowen, Bremen

AMA DELEGATES

Guy A. Owsley, Hartford City
Jack E. Shields, Brownstown
Harold C. Ochsner, Indianapolis
Eugene F. Senseny, Fort Wayne
Frank H. Green, Rushville

Fifty-Year Club—1967

BARTHOLOMEW-BROWN COUNTY

Lyman Overshiner, Columbus

LAKE COUNTY

Eli L. Levin, East Chicago

MARION COUNTY

Horace M. Banks, Indianapolis
John L. Glendening, Indianapolis
Karl M. Koons, Indianapolis
Roy Lee Smith, Indianapolis
Reuben A. Solomon, Indianapolis

MORGAN COUNTY

Horace R. Willan, Martinsville

PORTER COUNTY

John R. Frank, Valparaiso

SHELBY COUNTY

William D. Inlow, Shelbyville

VIGO COUNTY

William C. Kunkler, Terre Haute
Coen L. Luckett, Terre Haute

Photo Credits

Alex Studio, Indianapolis; Fabian Bachrach, New York; Chase Studio, Huntingburg; Noble Bretzman, Indianapolis; Bill Ehrich Studio, Indianapolis; Francis O. Galbraith, Columbus; Gary Post Tribune, Gary; Gill Studio, Martinsville; Halton Jones, Louisville, Ky; Holland & Rogers Studio, Indianapolis; Lawrence Krehe Studio, Marion; McDonald Studio, South Bend; Olan Mills, Springfield, Ohio; P. S. Ho Studio, Indianapolis; Phillips Photo Center, Lafayette; Starks Studio, Bloomington; Naiman's Studio, Washington, D.C.; Cusick Studio, Louisville, Ky.; Tom Toy Studio, Elkhart.

1966-1967

Officers of the ISMA



EUGENE S. RIFNER, M.D.

President

Indiana State Medical Association

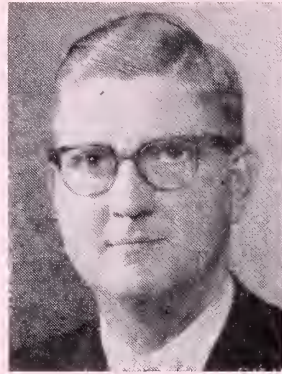
1966-67



G. O. LARSON, M.D.
President-Elect
LaPorte



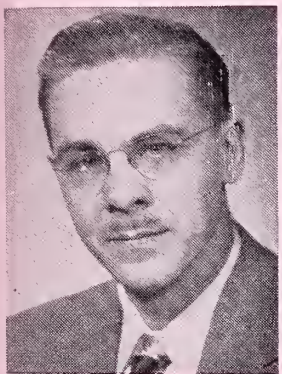
OTTIS N. OLVEY, M.D.
Treasurer
Indianapolis



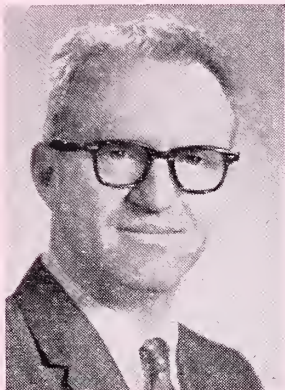
LOWELL H. STEEN, M.D.
Chairman of Council
Whiting



RALPH V. EVERLY, M.D.
Chairman
Executive Committee
Indianapolis



LESTER HOYT, M.D.
Asst. Treasurer
Indianapolis



BURTON E. KINTNER, M.D.
Executive Committee
Elkhart



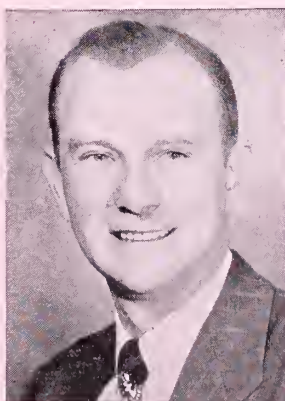
ROBERTA S. DEEVER
President, Auxiliary
Indianapolis



JAMES A. WAGGENER
Executive Secretary
Indianapolis



KENNETH W. BUSH
Administrative Assistant
Indianapolis



ROBERT J. AMICK
Field Secretary
Scottsburg



HOWARD GRINDSTAFF
Field Secretary
Indianapolis



ROBERT ROBINSON
Legal Counsel
Indianapolis

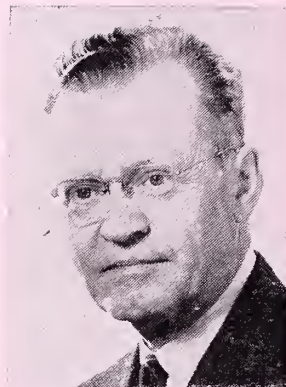
The Journal



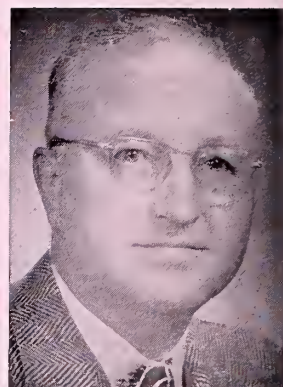
FRANK B. RAMSEY, M.D.
Editor
Indianapolis



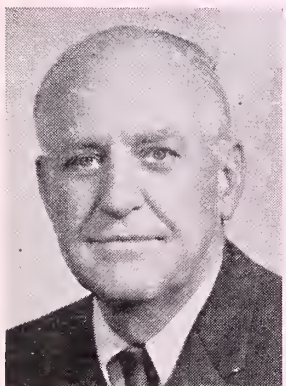
A. W. CAVINS, M.D.
Associate Editor
Terre Haute



L. G. MONTGOMERY, M.D.
Associate Editor
Muncie



DAVID A. BICKEL, M.D.
Associate Editor
South Bend



SAMUEL R. MERCER, M.D.
Associate Editor
Fort Wayne



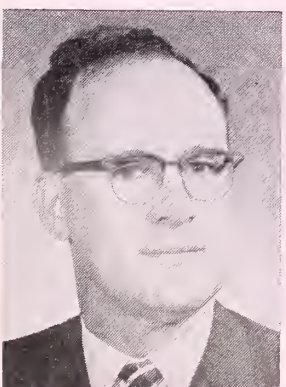
IRVIN W. WILKENS, M.D.
Associate Editor
Indianapolis



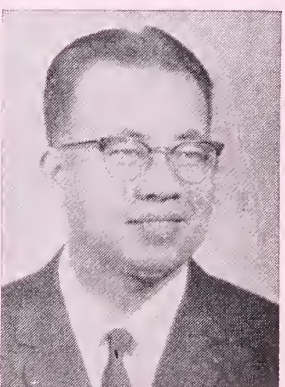
HAROLD D. LYNCH, M.D.
Editorial Board
Evansville



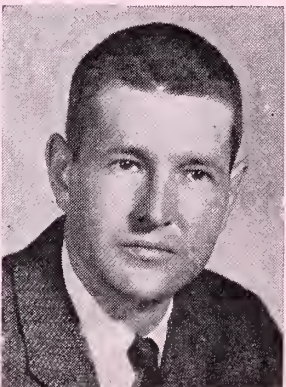
JENE R. BENNETT, M.D.
Editorial Board
South Bend



ALVIN J. HALEY, M.D.
Editorial Board
Fort Wayne



WEI-PING LOH, M.D.
Editorial Board
Gary



JACK W. HICKMAN, M.D.
Editorial Board
Indianapolis

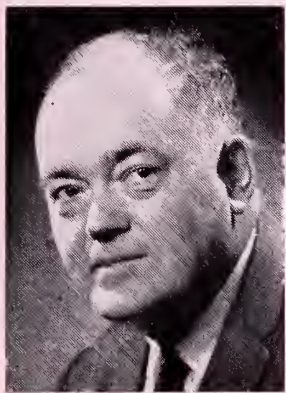


FRANK H. COBLE, M.D.
Editorial Board
Richmond

Section Officers

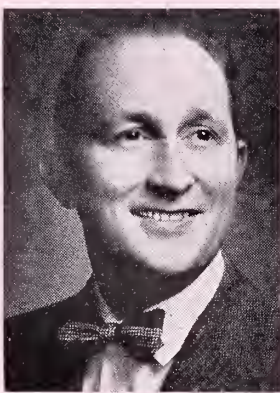
Surgery

CHAIRMEN



JOSEPH C. FINNERAN, M.D.
Indianapolis

VICE-CHAIRMEN



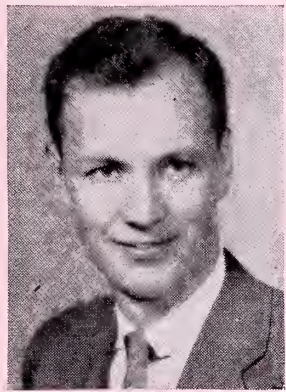
DONALD M. SCHLEGEL, M.D.
Indianapolis

SECRETARIES

NO
PICTURE
AVAILABLE

HENRY LARZELERE, M.D.
Marion

Internal Medicine



CHARLES M. SINN, M.D.
Evansville



LOUIS F. SANDOCK, M.D.
South Bend

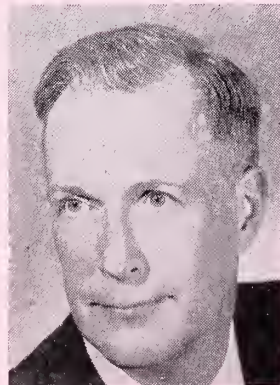


ROBERT L. RUDESILL, M.D.
Indianapolis

Ophthalmology and Otolaryngology



M. RICHARD HARDING,
M.D.
Indianapolis



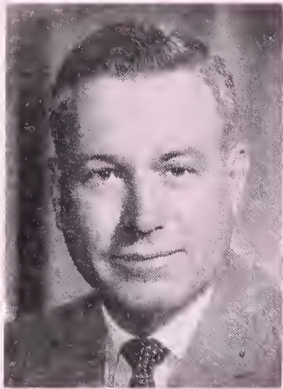
DAVID E. BROWN, M.D.
Indianapolis



GEORGE A. CLARK, M.D.
Indianapolis

Anesthesiology

CHAIRMEN



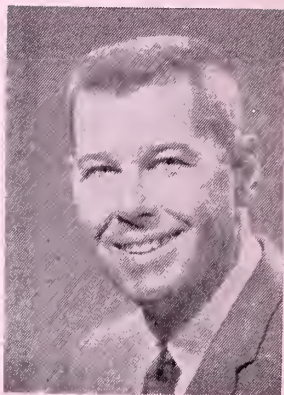
EUGENE SCHMIDT, M.D.
Fort Wayne

VICE-CHAIRMEN



WILLIAM M. MATTHEWS,
M.D.
Indianapolis

SECRETARIES

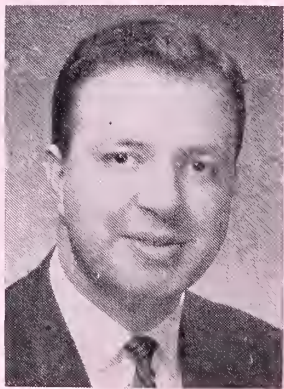


JERRY R. MILLER, M.D.
Indianapolis

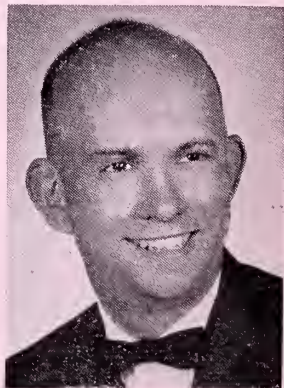
General Practice



ROSS L. EGGER, M.D.
Middletown



JAY S. REESE, M.D.
Martinsville



ROBERT MOUSER, M.D.
Indianapolis

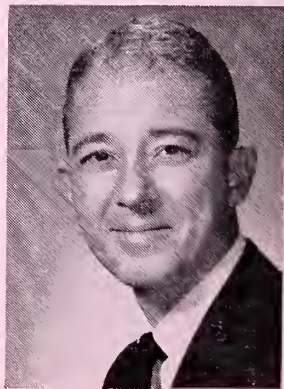
Obstetrics and Gynecology



JOSEPH F. THOMPSON, M.D.
Indianapolis



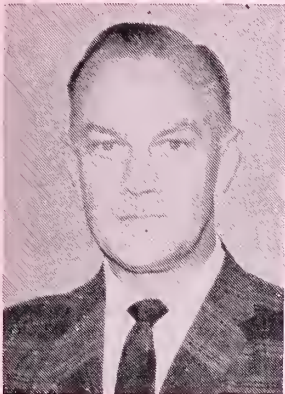
ROBERT M. REID, M.D.
Columbus



TOM W. WACHOB, M.D.
Kokomo

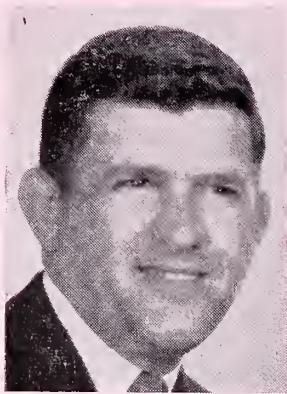
Public Health and Preventive Medicine

CHAIRMEN



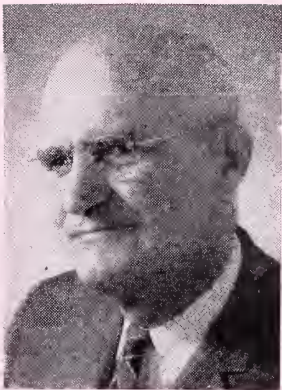
DONALD M. KERR, M.D.
Bedford

VICE-CHAIRMEN



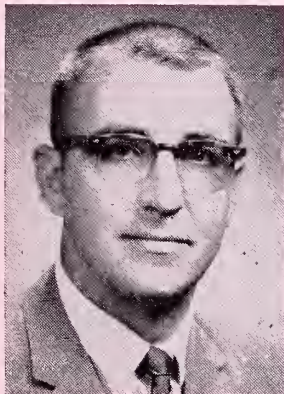
T. NEAL PETRY, M.D.
Delphi

SECRETARIES



HENRY G. NESTER, M.D.
Indianapolis

Radiology



RICHARD A. SILVER, M.D.
Indianapolis



JOHN A. ROBB, M.D.
Indianapolis

NO
PICTURE
AVAILABLE

EDWIN F. KOCH, Jr., M.D.
Muncie

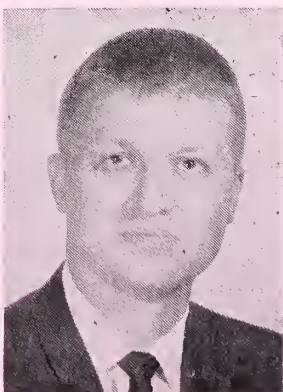
Nervous and Mental Diseases



DONALD F. MOORE, M.D.
Indianapolis



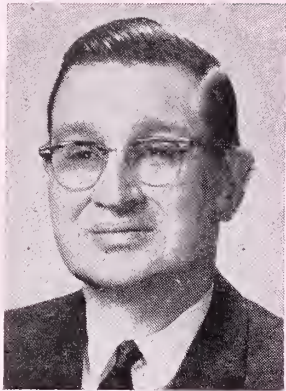
HANS MEYER, M.D.
Westville



GENE E. LYNN, M.D.
Indianapolis

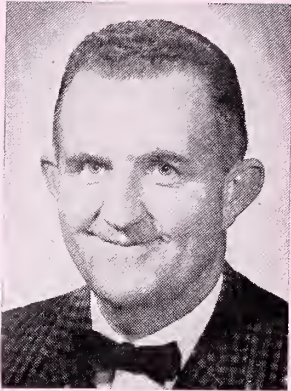
Pathology

CHAIRMEN



JOSEPH HAYMOND, M.D.
Indianapolis

VICE-CHAIRMEN



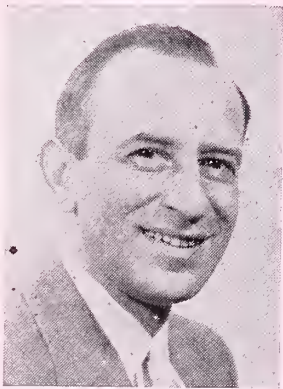
ROBERT J. FROST, M.D.
Michigan City

SECRETARIES

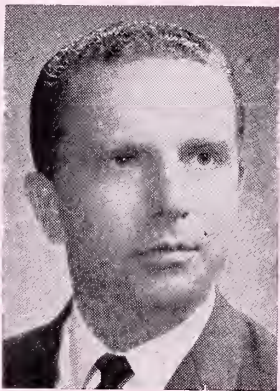


ROBERT L. COSTIN, M.D.
Indianapolis

Pediatrics



ROLAND E. MILLER, M.D.
Lafayette



GORDON T. BROWN, M.D.
Indianapolis



MORRIS GREEN, M.D.
Indianapolis

Schedule of Events

118th Annual Convention Indiana State Medical Association Murat Temple, Indianapolis, Indiana

October 9, 10, 11 and 12, 1967

(All Events on Eastern Standard Time)

(The scientific program of the 118th annual convention of the Indiana State Medical Association is acceptable for 12¼ elective hours by the American Academy of General Practice.)

Sunday, October 8, 1967

6:00 p.m. Executive Committee dinner meeting, Walnut Room, Columbia Club.

Monday, October 9, 1967

7:30 a.m. Council breakfast meeting, Walnut Room, Columbia Club.

2:00 p.m. Meeting of House of Delegates, Ballroom, Columbia Club.

7:00 p.m. Reference Committees meet, Columbia Club.

Tuesday Morning, October 10, 1967

8:00 a.m. Council breakfast meeting, Walnut Room, Columbia Club.

8:00 a.m. Annual golf tournament. Eighteen holes, low gross, banker's handicap and blind bogie medal play, Speedway Golf Course.

8:30 a.m. Registration begins, Theatre lobby, Murat Temple.

8:30 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple.

9:00 a.m. Reference Committee meetings continue, basement dining room, Murat Temple.

10:00 a.m. Annual skeet and trap shoot, Indiana Gun Club.

11:00 a.m. Editorial Board meeting, Ladies Parlors, (small room), Athenaeum. (Luncheon at 12 noon).

11:00 a.m.

to

2:00 p.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

Tuesday Noon, October 10, 1967

SECTION MEETINGS

11:00 a.m. SECTION ON NERVOUS AND MENTAL DISEASES and Indiana Neuropsychiatric Association joint luncheon meeting, Veterans Room, Athenaeum.

Business meeting.

Election of Section officers for 1968.

"The Neuropsychiatric Evidence Needed in Social Security Disability Evaluations,"

KURT NUSSBAUM, M.D., Baltimore, Md.

11:00 a.m. SECTION ON PEDIATRICS luncheon meeting, Foyer, Candidates Room, Murat Temple.

"Newborn Intensive Care, an Attempt to Reduce Infant Mortality,"

WILLIAM E. SCULLY, M.D.,

Terre Haute

Discussion, questions and answers.

Election of Section officers for 1968.



KURT NUSSBAUM, M.D.
Baltimore, Md.

Assistant Professor of Psychiatry, Johns Hopkins University Medical School; Chief Consultant in Psychiatry and Neurology to the Bureau of Disability Insurance, Social Security Administration; M.D. degree from the Medical Academy of Dusseldorf, 1932.



WILLIAM E. SCULLY, M.D.
Terre Haute

Specialist in pediatrics; certified by American Board of Pediatrics, 1963; Engaged in clinical research while continuing his regular practice; M.D. degree from the University of Cincinnati, 1958.



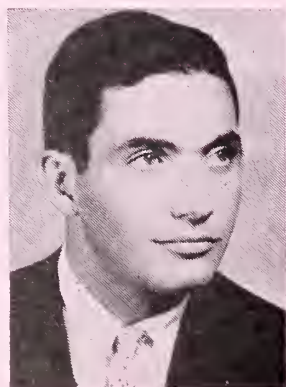
JAMES C. KING, M.D.
Chicago, Ill.
Associate Regional Health Director, the Bureau of Health Services, United States Public Health Service, Region V, Chicago, Ill.; specialist in surgery and public health; M.D. degree from Newcastle Upon Tyne, England, 1952.

GOETHE LINK, M.D.
Indianapolis
Specialist in thyroid surgery; Director Anatomical Laboratory, Central College of Physicians and Surgeons, Indianapolis; one of the organizers of the Indiana University School of Medicine; President of the Marion County Medical Society, 1942; Chairman of the ISMA Section on Surgery, 1919; M.D. degree from the Central College of Physicians and Surgeons, Indianapolis, 1902.



RALSTON R. HANNAS, Jr., M.D.
Kansas City, Mo.
Director, Division of Education, the American Academy of General Practice; secretary, the AAGP Commission on Education; secretary, the AAGP Commission on Hospitals; secretary, Committee on Requirements for Certification; M.D. degree from Harvard Medical School, 1950.

CHARLES R. ECHT, M.D.
Indianapolis
Assistant Professor, Obstetrics and Gynecology, I.U. School of Medicine; Diplomate of the American College of Obstetrics and Gynecology; M.D. degree from the I.U. School of Medicine, 1957.



SECTION MEETINGS

11:30 a.m. SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE luncheon meeting, Ladies Parlors, (large room), Athenaeum.

"Development of Comprehensive Community Health Services — the Role of the Local Official Health Agency,"

JAMES KING, M.D., Chicago, Ill.

Election of Section officers for 1968.

12 noon SECTION ON SURGERY, Indiana Chapter, American College of Surgeons, and Indiana Section, International College of Surgeons joint luncheon meeting, East Room, Athenaeum.

"The History of Surgery in Indiana,"

GOETHE LINK, M.D., Indianapolis

Election of Section officers for 1968.

12 noon SECTION ON INTERNAL MEDICINE luncheon meeting, Kneipe Room, Murat Temple.

Election of Section officers for 1968.

12 noon SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY business luncheon meeting, Palm Room, Athenaeum.

Election of Section officers for 1968.

12 noon SECTION ON GENERAL PRACTICE luncheon meeting, Basement Dining Room, Murat Temple.

"The Evolution of a New Specialty,"

RALSTON R. HANNAS, Jr., M.D.,
Kansas City, Mo.

Election of Section officers for 1968.

12 noon SECTION ON OBSTETRICS AND GYNECOLOGY luncheon meeting, Basement Foyer, Murat Temple.

12:45 p.m. *"Some Newer Concepts in Ovulation Induction Drugs,"*

CHARLES R. ECHT, M.D., Indianapolis

Election of Section officers for 1968.

SECTION MEETINGS

12 noon Joint luncheon meeting of SECTION ON RADIOLOGY, and Indiana Roentgen Society, Blue Room, Athenaeum.

"Electron Beam Therapy in Head and Neck Cancer,"

RALPH M. SCOTT, M.D.,
Louisville, Ky.

Election of Section officers for 1968.

RALPH M. SCOTT, M.D.
Louisville, Ky.

Professor of Radiology and Director of Radiation Therapy, University of Louisville School of Medicine; Member of the Board of Trustees, and the Commission on Cancer, American Board of Radiology; M.D. degree from the Medical College of Virginia, 1950.



12 noon SECTION ON PATHOLOGY luncheon meeting, Fraternity Room, Athenaeum. (All members of the Indiana Association of Pathologists and others interested are cordially invited to attend).

"Multiphasic Health Screening Procedures Using Automated Equipment,"

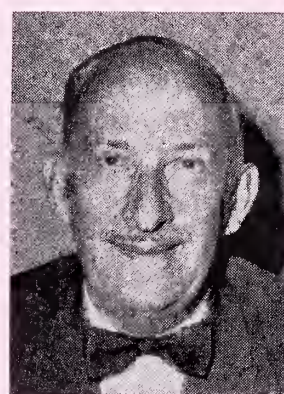
ROGER M. BUSLEE, M.D., South Bend

"Experiences of Pathologist Members of the ISMA with Direct Billings in Hospitals,"

Panel discussion:

LEON L. BLUM, M.D., Terre Haute
GEORGE E. BRANAM, M.D., Muncie
MERRITT O. ALCORN, M.D., Madison
CHRISTOS D. GATZIMOS, M.D., Wabash
OLIVER J. NEIBEL, Jr., Chicago

Election of Section officers for 1968.



LEON L. BLUM, M.D.
Terre Haute

Director of Laboratories, Union Hospital, Terre Haute; Specialist in clinical pathology; Senior partner, Terre Haute Medical Laboratory; M.D. degree from Friedrich-Wilhelm University, Berlin, Germany, 1933.

SECTION ON ANESTHESIA. No meeting during ISMA convention due to conflict with national meeting in Las Vegas.

12 noon Luncheon meeting of past presidents of the Indiana State Medical Association, Parlor A, Columbia Club.

12 noon Phi Beta Pi luncheon, Auditorium Room, Athenaeum.

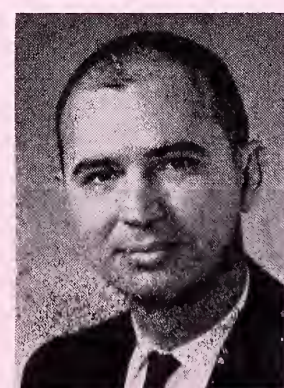
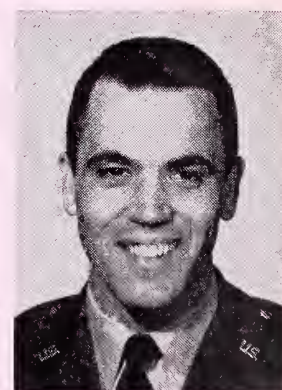
12 noon Phi Chi luncheon, Auditorium Room, Athenaeum.

12 noon Nu Sigma Nu luncheon, Auditorium Room, Athenaeum.

12 noon Phi Rho Sigma luncheon, Auditorium Room, Athenaeum.

GEORGE E. BRANAM, M.D.
Muncie

Pathologist, Ball Memorial Hospital, Muncie; Specialist in pathology; M.D. degree from the Indiana University School of Medicine, 1957.



MERRITT O. ALCORN, M.D.
Madison, Ind.

Specialist in pathology; President, Indiana State Board of Medical Registration and Examination; M.D. degree from the University of Arkansas School of Medicine, 1950.

Tuesday Afternoon, October 10, 1967

1:00 p.m. Flying Physicians Association, Indiana Chapter, meeting, Candidates Room, Murat Temple. (Not a luncheon meeting).

GENERAL MEETING

(Egyptian Room, Murat Temple)
Call to order by Eugene S. Rifner, M.D.,
Van Buren, president, Indiana State Medical Association.

2:00 p.m. *"Present Status of Kidney Transplants,"*
STUART ALLEN KLEIT, M.D.,
Indianapolis
"Natural and Acquired Immunity to Cancer,"
HENRY G. HADLEY, M.D.,
Washington, D. C.
"Radiotherapy of Hodgkin's Disease,"
RALPH M. SCOTT, M.D.,
Louisville, Ky.

2:00 to

4:00 p.m. Continuous professional MOVIES, Candidates Room, Murat Temple

1. CANCER IN CHILDREN (27 minutes)
2. DIAGNOSIS AND MANAGEMENT OF CANCER OF THE COLON AND RECTUM (17 minutes)
3. NURSING MANAGEMENT OF THE PATIENT WITH CANCER (29 minutes)
4. ORAL CANCER (22 minutes)
5. TUMORS OF THE MAJOR SALIVARY GLANDS (15½ minutes)

(Films supplied by Indiana Division, American Cancer Society)

4:00 to

5:00 p.m. Time allowed to view technical and scientific exhibits.

SPEAKER



HENRY G. HADLEY, M.D.
Washington, D.C.
Specialist in internal medicine; Diplomate, American Board of Internal Medicine; Emeritus Fellow, College of Chest Physicians; M.D. degree from George Washington University School of Medicine, 1917.

Tuesday Evening, October 10, 1967

6:00 p.m. Cocktail hour and annual dinner meeting for women physicians of Indiana, Parlors D and E, fifth floor, Indianapolis Athletic Club.

Speaker:

MRS. WILBUR F. PELL, Shelbyville

7:00 p.m. Annual Council Dinner, Hunt Room. Stouffer's Indianapolis Inn.

Fireside Conferences

on

CARDIORESPIRATORY DISEASES

Tuesday, October 10, 1967, 8:00 P.M.

Ballroom, Columbia Club

Topics for Discussion

1. *Intensive Cardiac Care*
2. *Impact of Chemoprophylaxis of TB*
3. *Office Management of Breathing Problems*
4. *Intensive Respiratory Care*
5. *The Traumatized Chest*
6. *Lung Biopsy Methods*
7. *Arrhythmias*
8. *Role of Cardiac Catheterization*
9. *Pericardial Disease*
10. *Medical Problems Attending Cardiac Surgery*

The Fireside Conferences, held annually during the state convention, are sponsored jointly by the Indiana Chapter, American College of Chest Physicians and the Indiana State Medical Association, and are open to all members of the state medical association.

The Conferences are informal and unrehearsed, and provide an opportunity for free discussion of many subjects of interest to the general practitioner, as well as to the specialist. A panel of experts will be seated at each of ten tables, and physicians are encouraged to ask questions, express their own ideas and comment on the various problems under discussion. The physicians are free to move from table to table as they wish.

JOURNAL of the Indiana State Medical Association

Wednesday Morning, October 11, 1967

SPEAKERS

- 8:00 a.m. Council breakfast meeting, Walnut Room, Columbia Club.
- 8:30 a.m. Registration continues, Theatre lobby, Murat Temple.
- 8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.
- 9:00 a.m. Meeting of small county delegates, Candidates Room, Murat Temple.

GENERAL MEETING

(Theatre, Murat Temple)

Eugene S. Rifner, M.D., Van Buren, president,
Indiana State Medical Association, presiding.

The Indiana University School of Medicine reports to the Indiana State Medical Association:

- 9:00 to
9:30 a.m. *"Medical School Curriculum: Past — Present — Future."*
WILLIAM P. DEISS, Jr., M.D.,
Indianapolis
- 9:30 to
10:00 a.m. *"The Indiana University Plan for Medical Education,"*
GLENN W. IRWIN, Jr., M.D.,
Indianapolis
- 10:00 to
10:30 a.m. *"Heart — Cancer — Stroke; Indiana Regional Program,"*
ROBERT B. STONEHILL, M.D.,
Indianapolis
- 10:30 to
10:40 a.m. Intermission

WILLIAM P. DEISS, Jr., M.D.

Indianapolis

Professor of Biochemistry and Medicine, Indiana University School of Medicine; Specialist in endocrinology and metabolism; M. D. degree from the University of Illinois School of Medicine, 1945.



GLENN W. IRWIN, JR., M.D.

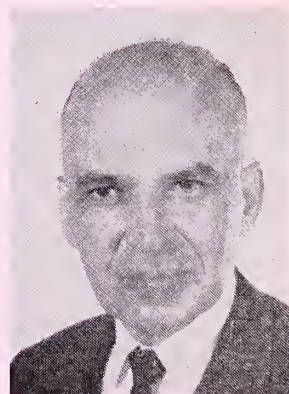
Indianapolis

Professor of Medicine and Dean, Indiana University School of Medicine; M.D. degree from the Indiana University School of Medicine, 1944.

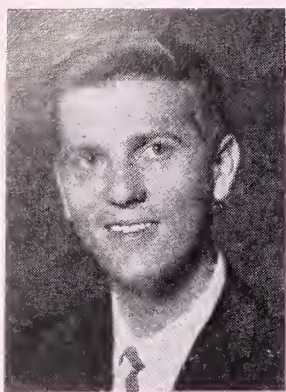
ROBERT B. STONEHILL, M.D.

Indianapolis

Professor of Medicine, Indiana University School of Medicine; Specialist in internal medicine, pulmonary diseases and aviation medicine; M.D. degree from the Temple University School of Medicine, 1945.



SPEAKERS



JACK H. HALL, M.D.
Indianapolis

Director of Medical Education, Methodist Hospital Graduate Medical Center, Indianapolis; Director of Cardiovascular Laboratory, Methodist Hospital; M.D. degree from the Indiana University School of Medicine, 1956.

JOSEPH M. BLACK, M.D.
Seymour

General practitioner; Former president of the I.U. Alumni Association; Member of the National Academy Commission on Legislation and Public Relations; M.D. degree from the I.U. School of Medicine, 1941.



A. C. OFFUTT, M.D.
Indianapolis

State Health Commissioner; Secretary, Indiana State Board of Health; Specialist in public health; M.D. degree from the Indiana University School of Medicine, 1940.



PAUL HARVEY
Chicago, Ill.

ABC news commentator; columnist and news analyst; Awarded seven honorary doctorate degrees, four Gold Medals from Valley Forge's Freedoms Foundation and numerous veterans and American Legion citations.



JAMES H. GOSMAN, M.D.
Indianapolis

Assistant Professor at the Indiana University School of Medicine and the Methodist Hospital Graduate Medical Center; Specialist in dermatology; Past-president, Marion County Medical Society; M.D. degree from Indiana University School of Medicine, 1938.



Wednesday Morning, October 11, 1967

GENERAL MEETING Continues

10:40 to

11:00 a.m. *"Indiana Senate Bill No. 359 — An Explanation,"*

Medical Education Board:

JACK H. HALL, M.D., Indianapolis

GLENN W. IRWIN, Jr., M.D.,
Indianapolis

JOE M. BLACK, M.D., Seymour

ANDREW C. OFFUTT, M.D.,
Indianapolis

11:00 a.m.

to 12 noon *Panel discussion:*

GLENN W. IRWIN, Jr., M.D., Moderator

ROBERT B. STONEHILL, M.D.

WILLIAM P. DEISS, M.D.

Medical Education Board

11:00 a.m.

to noon Time allowed to view technical and scientific exhibits.

11:00 a.m. Reception for members of Fifty-Year Club, Foyer, Candidates Room, Murat Temple.

Wednesday Noon, October 11, 1967

12 noon President's luncheon, Egyptian Room, Murat Temple.

"PAUL HARVEY and the News"

Presentation of scientific awards.

GENERAL MEETING

(Theatre, Murat Temple)

Eugene S. Rifner, M.D., Van Buren, president,
Indiana State Medical Association, presiding

2:30 p.m. Program sponsored by Medical and Scientific Committee of the American Cancer Society, Indiana Division, Inc.

Moderator: JAMES H. GOSMAN, M.D.,
Indianapolis, chairman, Physicians
Subcommittee, American Cancer Society

"Improving Prognosis with Early Detection of Cancer,"

VICTOR A. GILBERTSEN, M.D.,
Minneapolis, Minn.

"The Epidemiology of Skin Cancer,"
FREDERICK URBACH, M.D.,
Philadelphia, Pa.

"Problems of Cervix Cancer Control,"
WILLIAM M. CHRISTOPHERSON,
M.D., Louisville, Ky.

"Diagnosis and Treatment of Soft Tissue Sarcomas,"

LEMUEL BOWDEN, M.D.,
New York, N.Y.

Panel — Questions and answers.

4:00 to

5:00 p.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

Wednesday Evening, October 11, 1967

6:00 p.m. I. U. Class of 1927 reunion (dinner meeting), Athenaeum.

8:00 p.m.
to

12:30 a.m. Gaslight Party, Indianapolis Athletic Club.

Thursday Morning, October 12, 1967

9:00 a.m. Final meeting of House of Delegates, Ballroom, Columbia Club.
Election of officers.

Meetings of Council and Executive Committee immediately following adjournment of House of Delegates.

VICTOR A. GILBERTSEN, M.D.
Minneapolis, Minn.

Assistant Professor of Surgery and Director, Cancer Detection Center, University of Minnesota Medical School, Minneapolis; Diplomate of the American Board of Surgery; M.D. degree from the University of Minnesota Medical School, 1953.



FREDERICK URBACH, M.D.
Philadelphia, Pa.

Professor and Chairman, Department of Dermatology, The Skin and Cancer Hospital of Philadelphia, Temple University Health Science Center, Philadelphia; M.D. degree from Jefferson Medical College, Philadelphia, 1946.

WILLIAM M. CHRISTOPHERSON, M.D.
Louisville, Ky.

Professor and Chairman, Department of Pathology, University of Louisville School of Medicine, Louisville; Chief Pathologist, Louisville General Hospital; M.D. degree from the Louisville School of Medicine, 1942.



LEMUEL BOWDEN, M.D.
New York, N. Y.

Associate Attending Surgeon, Sloan Kettering Institute for Cancer Research, Memorial Hospital, New York, N.Y.; Consultant in neoplastic diseases; M.D. degree from Harvard Medical School, 1939.

Auxiliary Program

Mrs. Thomas W. Johnson, chairman

Tuesday, October 10, 1967

9:00 a.m.
to
5:00 p.m. Registration, Murat Temple

10:00 a.m. Open Board meeting, Parlor B, Columbia Club
Coffee between 9:30 and 10:00 a.m.

11:30 a.m.
to
12:30 p.m. Social hour

12:30 p.m. Luncheon, Ballroom, Columbia Club

Wednesday, October 11, 1967

9:00 a.m. Registration continues, Murat Temple

12:00 noon ISMA President's luncheon, Egyptian Room, Murat Temple

8:00 p.m.
to
12:30 a.m. Gaslight Party, Indianapolis Athletic Club.

Convention Arrangements Committees—1967

GENERAL CONVENTION ARRANGEMENTS:

Richard B. Hovda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E.

Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

ENTERTAINMENT: William M. Kendrick, Mooresville, assisted by Durward W. Paris, Kokomo

SCIENTIFIC EXHIBITS: Richard B. Hovda, Evansville

WOMEN PHYSICIANS: Betty Dukes, Dugger

WOMEN'S ENTERTAINMENT: Mrs. Thomas W. Johnson, Indianapolis, chairman

ART AND HOBBY SHOW: Charles P. Schneider, Evansville, and Ray H. Burnikel, Evansville, co-chairmen

MEN'S GOLF TOURNAMENT: Boyd A. Burkhardt, Tipton

TRAP-SKEET SHOOT: Claude M. Donahue, Carmel

Reference Committees—1967

REFERENCE COMMITTEE NO. 1:

T. Neal Petry, Delphi (Carroll),
Chairman
James A. Harshman, Kokomo (Howard)
Joseph L. Haymond, Indianapolis (Marion)
Seymour Shapiro, Gary (Lake)
Truman E. Caylor, Bluffton (Wells)

REFERENCE COMMITTEE NO. 2:

Jack W. Hickman, Indianapolis (Marion), *Chairman*

John D. Wilson, Evansville (Vanderburgh)
John S. Farquhar, Fort Wayne (Allen)
Kenneth O. Neumann, Lafayette (Tippecanoe)
Frank McGue, Michigan City (LaPorte)

REFERENCE COMMITTEE NO. 3:

Leslie M. Baker, Aurora (Dearborn-Ohio), *Chairman*
Robert M. Brown, Marion (Grant)
Vincent J. Santare, Munster (Lake)

Daniel M. Hare, Evansville (Vanderburgh)
Don E. Wood, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4:

Dean B. Jackson, Hartford City (Delaware-Blackford), *Chairman*
M. C. Topping, Terre Haute (Vigo)
Wayne H. Endicott, Greenfield (Hancock)
Robert G. Reed, Plymouth (Marshall)
Joseph M. Black, Seymour (Jackson-Jennings)

Reports of Officers

Executive Secretary

Doctor: In the following report we want to present to you some of the activities of your association during the past year. We hope this pictorial presentation will give you an idea of the



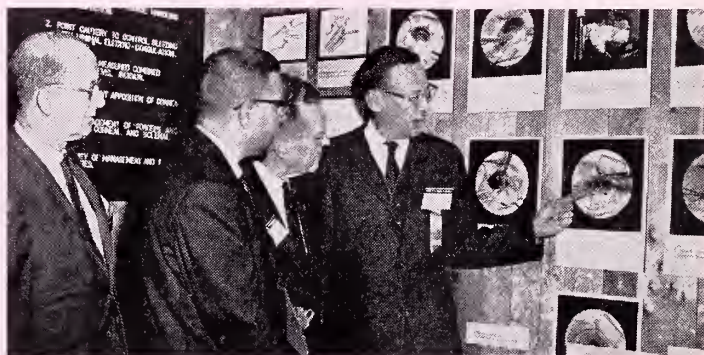
scope of activity. Behind all of it is the dedication of individual members who have been willing to sacrifice time to make the association an active, constructive force for the membership and for better health for Hoosiers.

MEETING OF THE HOUSE OF DELEGATES

Hub of the association's annual activity is the action of the House, which met in French Lick in October, 1966, to concern itself with policies of the ISMA. The convention, which demands 12 months of planning, as usual, kept officials and staff of ISMA busy, and in the true spirit of the democratic process, offered every member an opportunity to express his point of view.

SCIENTIFIC EXHIBITS

Physicians attending the annual convention took time to view the outstanding exhibit materials which are planned for ISMA members each year by the Commission on Convention Arrangements. Commercial exhibits, which add to the color and educational climate of the convention, each year help support, financially, the show.



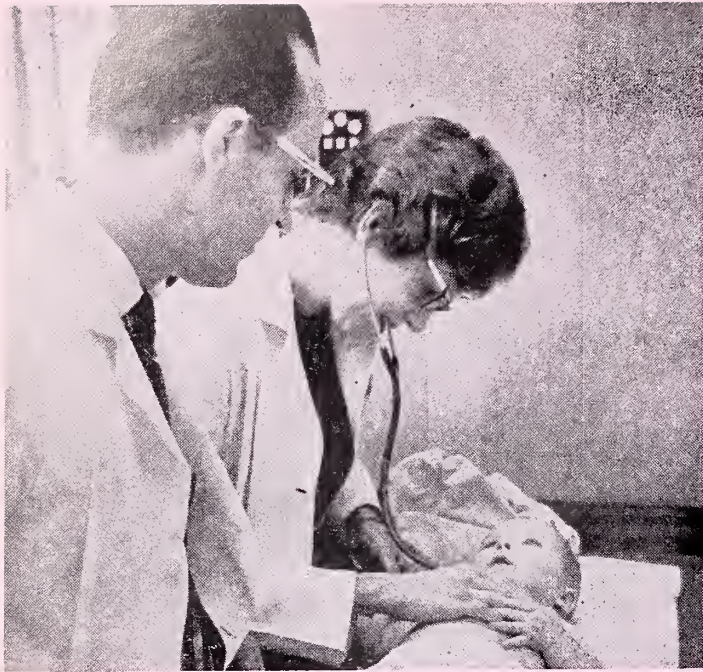
AWARDS PROGRAMS

Recognizing the outstanding efforts of many on behalf of organized medicine, the association, each year, makes awards to physicians, laymen, educators, journalists, scientists, artists and sportsmen, and to its elderly dedicated members. Physician members who volunteered for Viet Nam duty were cited at a meeting of the Council during the past year.

POLITICAL ACTION

Keenly aware of the need for vigorous and enthusiastic activity in the political arena, I-HOPE, the association's political education arm was reorganized, and with a new name, IMPAC, and a new symbol, launched a new period of activity.





PRECEPTOR PROGRAM

Enthusiastic senior medical student's acceptance of the preceptor program, a program visualized five years ago and established by the association two years ago, continued at a growing pace, giving students on-the-spot experience in medical practice in rural areas of Indiana.

CRASH INJURY RESEARCH

State Police and physician members of the association continued to work together in collecting and analyzing crash injury data to make automobiles and highways safer for Hoosiers.

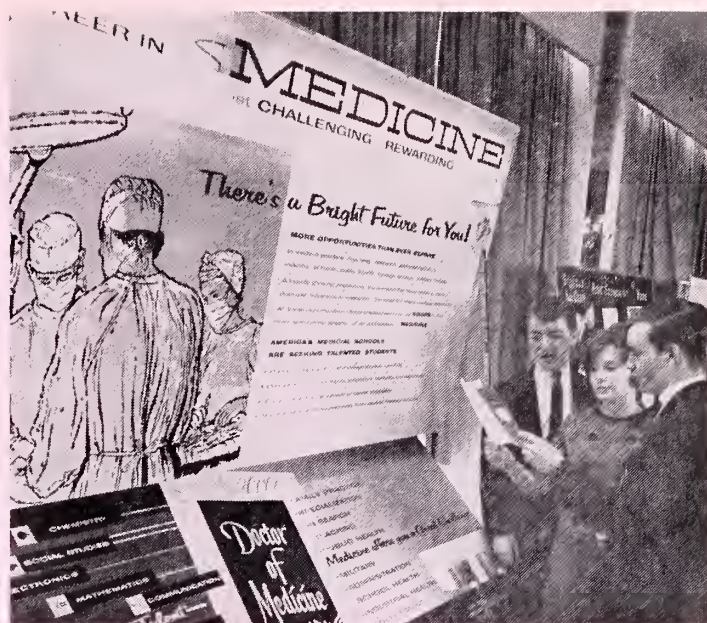


COMMISSION MEETINGS

Commissions, under the direction of the president, Doctor Rifner, continued to study problems of import to the association, using the headquarters office of ISMA as the center of activity. Detailed reports of their actions are published annually in The Journal of ISMA.

YOUTHPower CONFERENCE

Working cooperatively with the Indiana Farm Bureau and 42 other statewide organizations and industries, the association helped plan and execute this annual meeting of some of the state's outstanding young people. ISMA stressed the profession of medicine as a career.



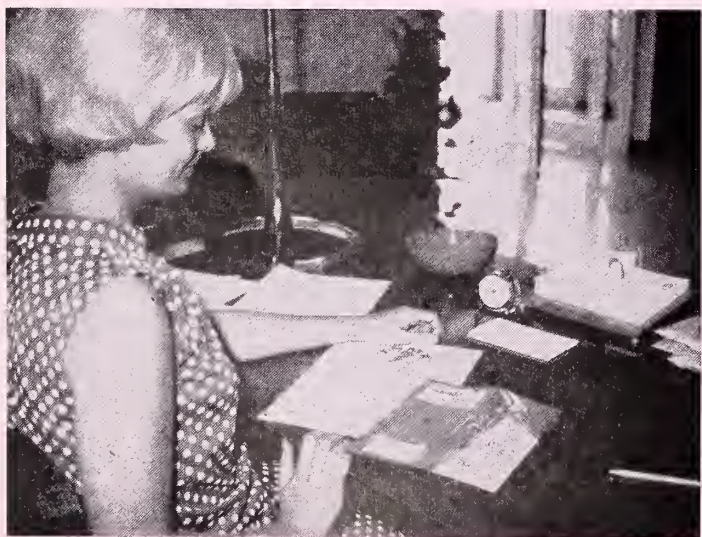
LEGISLATIVE ACTIVITY

One of the primary objectives of the association is to assist legislators in better understanding the medical viewpoint on legislative issues benefiting thereby the patient, the public and the profession. During the session of the Indiana General Assembly, more than 200 bills pertaining to health matters were studied with the objective of either supporting them, offering amendments or rejecting them. Trips were made to Washington, D.C., to gain audiences with the Indiana representatives in Congress.

MEDICINE AND VOLUNTARY HEALTH DAY

Second annual cooperative venture between the ISMA and Indiana's voluntary health agencies was held, establishing greater areas of understanding between these groups. Physicians, with membership in both the association and the agencies, influenced the success of this program.





JUNIOR-SENIOR DAY

Another highly successful Junior-Senior Day was held during the year. Objective of the one-day affair is to appeal to both the student and his wife, with emphasis on general practice in rural Indiana.

In other areas of activity, designed to benefit the individual physician directly, the association:

1. Provided legal advice to individual members or their societies. The acquisition of a lawyer as a full-time staff member of the association has augmented this service.
2. Acted as a clearing house for background and speech information for physician members on medical programs, medical careers, health statistics and health related education programs.
3. Provided administrative and program assistance for many district meetings, workshops and allied health groups.
4. Through its Grievance Committee, counseled in matters dealing with physician-patient relationships, physician-society relationships and inter-physician relationships.
5. Provided physicians and communities with information on physicians seeking locations.

In other areas, the association:

1. Conducted meetings with the Indiana Nurses Association and other association representatives, instituted a blood supply survey of hospitals, conducted a medical-self help television course, processed thousands of Medicare claims for its members and worked closely with Blue Shield in establishing policies.
2. Provided ISMA and AMA approved pamphlets and brochures to lay groups and individuals for instructive and educational purposes.
3. Collected, edited copy and produced *The Journal of ISMA*.
4. Printed numerous bulletins and promotional brochures on its own printing press.
5. Established a new department within the organization to concern itself full time with the problems of comprehensive health planning, traffic safety, and other federal and state programs which are health and welfare related.
6. Worked with press, radio and television to tell the story of the association's achievements and goals.
7. Advised and counseled the Woman's Auxiliary on programs and plans.
8. Prepared weekly health columns for 200 Indiana newspapers.
9. Sent its field secretaries over a combined 65,000 miles in Indiana to counsel, inform and assist members.

Your staff, of course, has worked industriously in all phases of these programs under the direction of the officers, Council members and commission members, and I wish to express to them my thanks for a job well done.

JAMES A. WAGGENER, *Executive Secretary*

The Treasurer

Inasmuch as the fiscal year of the association ends on September 30th and the audit is not available until around the first of November, it is usually impossible to present the audit for the year at the time of the meeting of the House of Delegates. Therefore the audit for the year ending September 30, 1966, is incorporated in my report for this year. In addition I will give you a cash report as of the 31st of July, 1967, which reflects the position of the association at the end of ten months of the current fiscal year:

SUMMARY OF ALL FUNDS:

	Cash	Investments	Total
General Fund	\$15,725.88	\$249,018.91	\$264,744.79
Journal Fund	90.73	—	90.73
Medical Defense Fund	1,745.08	30,000.00	31,745.08
Building Fund	2,819.98	—	2,819.98
Building Fund—Auxiliary Donation	—	3,777.71	3,777.71
Student Loan Fund (old)	2,133.02	13,280.65	15,413.67
Kitchen Fund	—	3,002.80	3,002.80
Total All Funds	\$ 22,514.69	\$299,080.07	\$321,594.76

Comparing this with the start of one year ago on July 31, 1966, we had total cash on hand in all funds of \$17,284.81 against the \$22,514.69 as of July 31, 1967, which gives us an increase of \$5,229.88. Our investment account as of July 31, 1966, amounted to \$262,320.23 as against \$299,080.07 at the end of July 31, 1967, for an increase of \$36,759.84. Total cash and investments of all funds as of July 31, 1966, amounted to \$279,605.04. The comparable figure as of July 31, 1967, is \$321,594.76 for an increase of \$41,989.72. The Executive Committee and the Council have reviewed the investment portfolio of the association at each of its meetings and the treasurer has followed the advice of these bodies by investing all cash in short term bills or in savings accounts in order to accumulate as much interest as possible where funds were not required for current purposes. Indications at the present time show we will be well within our budget for the fiscal year.

OTTIS N. OLVEY, M.D., Treasurer

First Councilor District

The annual meeting of the First District Medical Society was held in Evansville, May 25th at the Rolling Hills Country Club. Approximately 150 physicians and their wives attended. Mead Johnson and Company sponsored a social hour for the guests, preceding the dinner. Dr. Henry M. Johnson of Indianapolis gave a humorous talk following the dinner.

In the business session, presided over by Dr. Wallace M. Adye, president, the following officers were elected:

- Dr. Roland E. Weitzel, Princeton, president.
- Dr. Milton Anderson, Evansville, vice-president.
- Dr. James L. Hobgood, Evansville, secretary-treasurer.

Dr. George W. Willison was re-elected to the Indiana Blue Shield Board, and Dr. Gilbert M. Wilhelmus, alternate councilor.

The Vanderburgh County Medical Society set up a committee to work with *The Evansville Press* to prepare a series of newspaper articles on the first year of Medicare; these have been entered in the ISMA Journalism Award competition. A measles immunization campaign was sponsored in May.

The society's board of directors developed a policy setting up guidelines for groups of physicians to staff the emergency department in our general hospitals. Continuing efforts are being made to deal with this problem in the best interest of the public, the hospitals and the medical profession.

A good proportion of the district members continue to be active in medical organizational matters and community affairs.

The annual convention of the state auxiliary in Evansville last April was a particular highlight of the year.

PATRICK J. V. CORCORAN, M.D., Councilor

Third Councilor District

The Third Councilor District saw another year pass with a persistence of the apathy which helps to destroy the function of the medical association. Representation at the annual meeting was again that of the usual old faithful group and few others.

An excellent program for the members and their ladies was presented through the efforts of Dr. and Mrs. Dan Cannon and their committees. The meeting was held at the Robert E. Lee Motel in New Albany on May 17, 1967 and was attended by 25 members of the 150+ in the district.

The incumbent councilor was re-elected as was the incumbent president, Dr. Dan

Cannon. Bylaws and a constitution for the district were adopted and a change in policy of the district. It was the decision of the district as represented to forego the rotation of the meeting through the district and to instead hold the meetings in the Fall City area in recognition of the fact that attendance of the meeting is invariably better when they are held in that pocket of the district. Efforts to consolidate meetings with adjacent districts were initiated and it is hoped that we will next year combine meetings with the Fourth District in order to upgrade attendance, interest and programs through the combined effort.

In the preceding year, one district member was voted out of society membership by his local group and the consequent appeal to the Council by the affected member established a "first" in ISMA history. It is noteworthy that this member after a years probation renewed his application to county society membership and was re-instated.

Obvious was the fact that in this, as in most districts, some dissident members have practically deserted the organization, apparently in protest of what they feel to have been a desertion of their principles by the organization. It is the sincere hope of the councilor that these members will realize that he and the organization of which they are a part have also endured much frustration and futility in many hours of attempting to solve their problems which have been thrust—not by ISMA—but by their duly elected representatives. We must hang together or we will most certainly hang separately.

DONALD M. KERR, M.D., Councilor

Sixth Councilor District

The Sixth District Medical Meeting was held in Rushville, Wednesday, May 17, at the Durbin Hotel, at 3:00 P.M.

The program was as follows: Mr. John J. Carter, Vice President and Economist, Indiana National Bank, spoke on "Investments and Real Estate Planning." Dr. Richard McNabb of the Indiana University Medical Center spoke on "Child Behavior."

Following this portion of the program a business meeting was held and the following officers elected:

Councilor: Dr. Stephen Smith, Knightstown

President: Dr. Paul Inlow, Shelbyville

Vice-President: Dr. Stephen Smith, Knightstown

Secretary: Dr. Perry Seal, Brookville

A social hour was held with the wives who also joined their husbands for dinner. The program after the dinner was as

follows: Mr. Carter spoke on "Current Opportunities in the Investment Markets" and Dr. McNabb spoke on "Adolescent Problems."

The Elks Club Golf Course was available for those wishing to play golf with Dr. Donald Dean as chairman. The doctor's wives enjoyed a flower arranging demonstration during the evening. The educational seminar was sponsored by the Indiana Chapter of the American Academy of General Practice in cooperation with Eli Lilly & Company.

WILLIAM R. TINDALL, M.D., *Councilor*

Seventh Councilor District

The annual meeting of the Seventh District Medical Society was held at 6:30 p.m., Wednesday, May 17, 1967, at the Greenfield Laboratories of Eli Lilly and Company, with the president, Dr. Jay S. Reese, of Martinsville, presiding. Members of the society were guests of the company for a tour of the Greenfield facility and for a dinner preceding the meeting.

Dr. Reese introduced Dr. Kenneth G. Kohlstaedt, of Indianapolis, the company's Vice-President of Medical Research, who welcomed society members and presented C. W. Pettinga, Ph.D., Vice-President of Research, Development and Control, who discussed activities at the laboratories.

Dr. James H. Gosman, of Indianapolis, secretary-treasurer of the society, presented the treasurer's report, showing a bank balance, as of May 17, 1967, of \$894.57.

Dr. John O. Butler, alternate councilor from the Seventh District, discussed activities of the Council of the Indiana State Medical Association, and Dr. Gosman then reviewed a questionnaire submitted by the Future Planning Committee of the state association concerning better communication between districts and the association and within the districts. It was moved by Dr. William D. Province, of Franklin, with many seconds, that the questionnaire be sent to all district society members and that a statistical summary of the returns be prepared by the staff of the Marion County Medical Society. The motion was carried.

Dr. Harold C. Ochsner, of Indianapolis, delegate to the American Medical Association, and Dr. Gosman, as alternate delegate, then led a discussion concerning the AMA's disability income program. Dr. Ochsner advised that the Indiana delegation plans to support a change from the Continental Casualty Company, the present carrier, to the Fireman's Fund American Insurance.

Dr. Reese then introduced Dr. Glen V. Ryan, of Indianapolis, chairman of the Blue Shield Board of Directors, and Mr. Richard C. Kilborn, of Indianapolis, presi-

dent. Both spoke briefly.

Dr. Reese called for nomination of candidates for president-elect of the society and Dr. A. Alan Fischer, of Indianapolis, nominated Dr. John O. Butler. Dr. Province, with several seconds, moved that the nominations be closed and that Dr. Butler be declared elected unanimously. The motion was carried.

The president called for nominations of candidates for secretary-treasurer and Dr. Ochsner, with several seconds, nominated Dr. Gosman to succeed himself and moved that the nominations be closed and that Dr. Gosman be declared elected unanimously. The motion was carried.

Dr. Reese then relinquished control of the meeting to Dr. Harry E. Mock, Jr., of Franklin, his successor. Dr. Mock announced that the 1968 annual meeting of the society will be held in Franklin at a date to be announced later, and, by consent, declared the meeting adjourned.

ALBERT M. DONATO, M.D., *Councilor*

Eighth Councilor District

The Eighth District Medical Society met at the Portland Country Club on Wednesday, June 7, 1967. Attendance was poor. The Jay County Medical Society was the host organization with Dr. Donald Spahr serving as president and Dr. Joseph Vormohr as secretary-treasurer.

A lengthy business meeting was held, centering around the question as to what could be done to strengthen the annual district meetings. Various suggestions and ideas were discussed but no definite recommendations were arrived at. There was a general feeling that it was very difficult for the smaller societies to act effectively as hosts. Past experience has shown that the meetings in Muncie are the best attended, probably since it is centrally located and closer to the two large societies of the district.

It was agreed that the district councilor would hold a caucus of the delegates from the district during the annual convention of the Indiana State Medical Association to discuss this further and attempt to develop a long range solution.

Dr. Paul Sparks of Winchester was re-elected to a three year term as alternate councilor starting in October, 1967 and Dr. Fletcher McDowell of Muncie was re-elected to a three year term to the Blue Shield Board of Directors starting in the spring of 1968.

The 1968 district meeting is tentatively scheduled for Anderson on June 5, 1968. Dr. William Stinson was elected president for 1968 and Dr. Charles King, secretary-treasurer.

DONALD R. TAYLOR, M.D., *Councilor*

Ninth Councilor District

The Ninth District meeting was held at Frankfort on May 18, 1967, with Tipton County as host society. This was in line with our previous discussion of attempting to have the councilor district meetings held at more centrally located cities. If the numerical attendance results are any criterion, it seems we are moving in the right direction.

The elections during the day resulted in Dr. Barton Bridge, a G.P. from Lafayette, being elected to the Blue Shield Board to replace Dr. R. Vermilya of the same city. The councilor was reelected to succeed himself.

During the past year, I have made an attempt to visit all of the component societies in our district and, for the most part, I have succeeded. It is a pleasure to meet, eat and talk with all of you and starting with the fall meetings, I shall attempt to do the same thing again. In this way we can alert one another to the problems we in medicine are facing in the ever-changing world of today.

Thank you for your help and continue your efforts with me in the future.

P. R. PETRICH, M.D., *Councilor*

Tenth Councilor District

The Tenth District held two meetings during the past year that had excellent attendance. Your councilor also appeared at most of the county society meetings to report on state association affairs.

The first district meeting was on September 21, 1966. A capacity turnout of 150 physicians and wives attended this dinner in honor of newly elected American Medical Association vice-president, E. S. "Jack" Jones. Dr. Ernest Howard, assistant executive vice-president of the American Medical Association, was introduced. During dinner, the councilor for the Tenth District conducted an election of officers with Dr. R. J. Bills being chosen president, and J. J. Reed being chosen secretary.

The councilor made an explanation of current affairs at the Indiana State Medical Association level, and discussed the business of the House of Delegates to be conducted October 10th to the 14th. Dr. Santare, president of the Lake County Medical Society, read and presented a plaque to Dr. Jones, citing his many contributions to medicine. Dr. Jones received a standing ovation and responded with a few words of appreciation.

Dr. Steen introduced Dr. Elvis J. Stahr, president of Indiana University, who spoke on "The Medical Education Needs of Indiana." Dr. Stahr urged support of the university's plan for expansion of the

present school, and stated that the construction of additional schools in the state should be postponed for several years. Dr. Stahr's presentation was ably given, and his reception was cordial, although several members took exception to the university plan.

The second meeting was May 3, 1967. This meeting was attended by 112 doctors and wives. Dr. R. J. Bills, president of the Tenth District Medical Society, presided. The following guests were introduced: Richard Kilborn, president, Indiana Blue Shield; Dorothy Nierengarten, director, and Thomas Bell, assistant director, Lake County Department of Public Welfare and Howard Jennings, Gary director of Social Security Administration.

Dr. Templin, president of the Lake County Medical Society, conducted a meeting during which minutes of the January meeting were approved as published. He then described the effort made in the 1967 General Assembly to bring about the construction of the school of medicine in northwest Indiana. He pointed out that the enormous sacrifice of time and energy on the part of Drs. Lowell H. Steen, S. W. Shapiro, R. J. Bills, John T. Scully, Leonard W. Neal, V. J. Santare and the society executive director J. B. Twyman, brought the northwest Indiana proposal from a late and last place early position, to one which nearly received legislative approval and received far more support than the proposal of any other community. He then pointed out the special contributions made by the following persons and organizations and presented each a framed certificate of appreciation from the society: Bishop A. Grutka; Gary Mayor Martin A. Katz; William J. Riley, president, Northwest Indiana Center Study Council; Senator E. Bainbridge; Rep. N. Angel; *Gary Post Tribune*; Gary Radio Station W.W.C.A.; A. F. L.-C. I. O.; Inland Steel Company and Phil McFerran, Gary Chamber of Commerce.

The Tenth District councilor gave a brief report on current affairs at the state level. He reaffirmed Dr. Templin's appeal for participation by local physicians in the plan to cooperate with Indiana University in intern and residency training programs in the local hospitals on a county-wide basis. He also described the efforts being made by ISMA and the AMA to alter some of the present provisions in the Medicare laws to make it easier for doctors to work with this law.

Dr. Bills introduced Dr. Dwight W. Schuster, chairman, Indiana State Medical Commission on Legislation, and Mr. Albert Kelly, director of Indiana Department of Public Welfare. The speakers described the operation of Title 18 and 19 of the

so-called Medicare and Medicaid laws. They and Mr. Kilborn answered many questions about the submission of claims, preparation of reports, determination of fees, etc.

LOWELL H. STEEN, M.D., *Councilor*

Twelfth Councilor District

The Twelfth District met May 17, 1967, in Fort Wayne at Cutter's Chalet where the annual business meeting was conducted in the afternoon, and the banquet and after dinner activities were held in the evening. The Indiana Academy of General Practice held a symposium on "Sexual Problems in Clinical Practice" which began at 10 a.m.

Dr. Warren Niccum presided at the meeting where 68 members were present. Reports were given by the district officers and the councilor and were accepted as presented.

New officers were named and Dr. Max Gitlin, Bluffton was elected president; Dr. Kenneth Isenogle, Fort Wayne, vice-president and Dr. Berniece Williams, Fort Wayne, secretary-treasurer. Dr. Mahlon Miller was reelected district Blue Shield representative. Dr. William R. Clark was elected councilor for a three year term and Dr. Fred Schoen was elected alternate councilor to fulfill the unexpired term of Dr. Clark. The district accepted the invitation of Steuben County to have the 1968 meeting at the Eaton Trout Club Wednesday, May 15, 1968.

After the banquet all guests were introduced by Dr. Niccum who did a fine job as master of ceremonies. The speaker of the evening was Dr. Jack Schreiber of Canfield, Ohio who presented his famous "The Last Candle." The context and presentation were most impressive.

This report is my last and it seems "just the other day", but it has been six years since I began as councilor for this district. During that period we've all experienced successes and failures—the prime success probably being the new ISMA headquarters—all built and paid for; the prime failure probably Medicare and its impact on the private practice of medicine. Much remains to be done to alter and modify Medicare and we can now look to Dr. Clark who will be a very fine representative of our best thinking.

Goodbye and so-long, it's been my pleasure.

MILTON F. POPP, M.D., *Councilor*

Thirteenth Councilor District

The Thirteenth District Medical Society has scheduled its meeting for Wednesday, Sept. 27, 1967 at the Indiana Club in South

Bend, Indiana.

The committee for arrangements and program are C. Burket, H. Davis, J. Hildebrand, G. Larson, E. Mueller, P. Macri, B. Gattman, G. Cook and O. Bowen. They have planned an interesting, informative and entertaining afternoon and evening.

Inasmuch as this district has had several physicians volunteer their services in Viet Nam, the early part of the program will be devoted to "Medicine in Viet Nam" with the panel being composed of Dr. George Bloom, M.D., Elkhart; Dr. Dana Troyer, M.D., Goshen, and Dr. J. G. Yoder, M.D., Middlebury, all of whom served in Viet Nam.

The latter part of the afternoon will be devoted to problems of our profession with titles of talks and speakers as follows: "What's Behind the Door?" by Ernest B. Howard, M.D., Assistant Vice-President of the American Medical Association; "Your Socio-Economic Future" by Mr. Robert E. Robinson, Attorney, Department on Research and Planning in the Field of Federal Health Programs, Indiana State Medical Association, and "What Kind of Glue Does it Take?", by Eugene S. Rifner, M.D., President, Indiana State Medical Association.

At 5:30 p.m. there will be a business meeting followed by a social hour at 6:00 p.m. sponsored by the Wayne Pharmaceutical Supply Company.

Dinner will be at 7:00 p.m. and the after-dinner speaker will be Mr. Harold L. Schuman, Secretary and General Manager, Indiana Manufacturer's Association, who will speak on: "What Indiana Makes, Makes Indiana."

OTIS R. BOWEN, M.D., *Councilor*

Editor of The Journal

The Journal is completing the year in satisfactory financial condition. Both sides of the ledger will probably be a little over what was expected when the budget was set, but it is expected that revenue and expense should be about equal. If there is an excess or deficit, the amount should be small.

Our advertising revenue from national accounts from January to August shows a 21% gain over the same period in 1966. The gain would have been considerably larger if several advertisements had not been cancelled in the late spring and early summer months because of uncertainties on the part of pharmaceutical manufacturers in regard to Food and Drug Administration standards on claims and wording.

Uncertainties as to advertising standards and the industry's caution in the situation may be solved soon, but there

is, as of now, no indication how long the problem will remain. Advertising revenue may be depressed for an indefinite period.

A new feature, which appears as often as suitable material presents itself, is the section headlined "Hospital Practice." Its mission is to report on new developments and advances in diagnosis and therapy which are characteristic of medical practice in hospitals. Several interesting articles of this type are planned for the coming year.

We continue to receive an adequate supply of short, appropriate scientific articles. These with the recurring features on cardiology, x-ray diagnosis and problem fractures, as well as Path-finder and clinical articles on cancer diagnosis fulfill our requirements for scientific content.

Delegates to AMA

The House of Delegates of the American Medical Association set two records at its recent meeting in Atlantic City, New Jersey.

One was attendance. After 95% of the authorized delegates attended the Sunday, June 18, opening session, 100% — 242 delegates out of 242 — were in their seats for both the Tuesday and Wednesday deliberations. Thursday, the final day, attendance still stood at 240.

The other was accomplishment. All told, the House was presented with 151 items of business on which action had to be taken, including a record total of 123 resolutions from state medical associations; 18 reports from the Board of Trustees, three of which were nominations to fill Council positions; four reports from the Council on Medical Service; three reports from the Council on Constitution and Bylaws, one produced during the convention in order to implement an adopted resolution; two reports from the Council on Medical Education; and one report from the Judicial Council nominating affiliate members of the Association.

The Indiana delegates were in attendance 100% and as one of them put it "batted" 1000 in the introduction and passage of Resolution 103 which dealt with drug dispensing provisions under Title 19.

Passage, however, was accomplished over the obstacle of the reference committee report which gave the resolution a "no" vote.

Speaking to the point, Dr. Maurice E. Glock, alternate delegate from Fort Wayne, opened debate in the House of Delegates on the reference committee action and the Indiana resolution was reinstated by a large majority.

Following is the text of the resolution: "Whereas, In the Handbook of Public Assistance Administration, Supplement D, 5150, dealing with Medical Assistance Pro-

grams under title XIX of the Social Security Act reads as follows:

'Federal financial participation is available in expenditures for medical or remedial care and services under the State plan which meet the definitions, items 1 through 15, in D 5141 (also see D 5800)

'Drugs — with respect to 'prescribed drugs' as defined in D 5141, item 12a, Federal financial participation is available in expenditures for drugs dispensed by licensed pharmacists, and, when dispensed by legally authorized practitioners, where no adequate pharmacy services exist or are available when needed, and the practitioner dispenses such drugs on his written prescription, and retains records thereof;'; and

"Whereas, This policy statement is to be proposed as a regulation; and

"Whereas, This tends to delimit the right of the physician to dispense drugs, increase his paperwork and leave an avenue open for argument as to who will define 'where no adequate pharmacy services exist or are available when needed'; therefore be it

"Resolved, That the American Medical Association voice its strenuous objection to the policy as enunciated in the Handbook and seek its removal as a policy and a possible regulation for dispensing drugs under Title XIX."

The delegates, alternate delegates, members of the Executive Committee and officers of the ISMA diligently represented the association at the convention and planned each day's activity at a 7 a.m. breakfast.

Dr. Lester H. Hoyt, Indianapolis, assistant treasurer of the ISMA, was elected chairman of the AMA's Section on Pathology and Physiology for 1967-1968.

Immediately following the convention, the Board of Trustees of the AMA, in a reorganization meeting, elected Dr. Lester Bibler, Indianapolis, to the executive committee of the board.

Dwight L. Wilbur, M.D., San Francisco, Cal., was elected president-elect of the AMA. Dr. Wilbur has been a member of the Board of Trustees since 1963. He will serve in his new capacity for one year and will be installed as the Association's 123rd president at its annual convention in his home city in June, 1968.

Malcolm E. Phelps, M.D., El Reno, Okla., who has been field director of the Volunteer Physicians for Vietnam program, was elected vice-president of the Association.

Walter C. Bornemeier, M.D., Chicago, Ill., was re-elected Speaker of the House and Russell B. Roth, M.D., Erie, Pa., was re-elected Vice Speaker of the House.

Four trustees were elected to succeed

themselves: Wesley W. Hall, M.D., Reno, Nev.; Irwin E. Hendryson, M.D., Denver, Colo.; Alvin J. Ingram, M.D., Memphis, Tenn.; and Robert C. Long, M.D., Louisville, Ky.

Edward R. Annis, M.D., Miami, Fla., was elected to complete the term on the Board of Trustees vacated by the death of Homer L. Pearson, M.D., Miami, Fla.; and Burt L. Davis, M.D., Palo Alto, Cal., was elected to complete the term as trustee vacated by the resignation from the Board of President-Elect Wilbur.

Thurman B. Givan, M.D., Brooklyn, N. Y., was elected to succeed himself on the Council on Constitution and Bylaws.

Earle M. Chapman, M.D., Boston, Mass. (succeeding himself), and Vernon E. Wilson, M.D., Columbia, Mo., were elected to the Council on Medical Education.

George W. Slagle, M.D., Battle Creek, Mich., was elected to succeed himself on the Council on Medical Service.

On the nomination of President Rouse, Elmer G. Shelley, M.D., North East, Pa., was elected to succeed himself on the Judicial Council.

The American Medical Association's Distinguished Service Award was presented by the House of Delegates to E. W. Alton Ochsner, M.D., of New Orleans, La.

At Sunday's opening session, the House heard outgoing President Charles L. Hudson, M.D., Cleveland, Ohio, urge physicians of the United States to "take the initiative and apply local solutions to local problems" in order to "persuade people that the proper function of government is to confine its activities to the support of private enterprise rather than to act as a competitor." Dr. Hudson stressed that it remains a continuing charge of physicians "to seek out and meet any discovered need for health care" and observed that "One of the greatest challenges facing the medical profession now and in the immediate future . . . is the organization of community health care."

At his Tuesday evening inauguration as the Association's 122nd President, Milford O. Rouse, M.D., Dallas, Tex., followed a similar theme in pointing out that "The federal government is making its moves into areas where, to its own satisfaction at least, it is able to demonstrate unfilled needs for health care or health care planning. If we are alert to our responsibilities for filling all of the apparent vacuums in community-wide health programs, we can eliminate areas which may seem to demand government involvement.

"Leadership will be provided," Dr. Rouse said, "in these areas of community planning and the provision of community health services for all people. The only undefined

factor is the source of that leadership. If it is not the physicians of the community, it will be government in one of its many forms."

President Rouse listed some of the many problems now facing the medical profession, asserting however that "this is a time not for despair, but for a clear recognition of crises that are approaching; a time not for anger and frustration, but for unswerving determination to face our problems and solve them; a time not for philosophy alone, but for action to make our philosophy a reality."

In his report to the House Thursday, President Rouse elaborated on that theme and listed what he considers to be some of the solutions to the problems facing medicine. Among the items he included were more unity within the medical profession; greater interprofessional harmony with all other elements of health care; better communications between physicians and their societies at every level, and between physicians and the public; increased participation by physicians in the deliberations and programs of the medical associations; more activity by physicians in the political and civic affairs of their communities; and the development of citizen interest in matters of over-all health.

"As we have done in the past," the President told the House, "we shall gladly respond to requests from government or from any other source for advice on health matters. . . . But, as in the past, we shall insist that we be approached in good faith, with the assurance that our freedom of judgment and freedom of action will be preserved."

"Our future," he concluded, "will not be determined by those who oppose us, but by our own willingness to accept the responsibilities which are naturally ours."

Actions of the House

Of the 10 reports from councils considered by the House, all were adopted in their presented form except two from the Council on Medical Service which were amended and adopted. Of the 18 Board of Trustees reports, 13 were adopted as presented; two were amended and adopted; two were accepted for information; and one was referred back to the Board along with state resolutions on the same subject.

After many hours of reference committee hearings and additional debate on the floor of the House, 27 of the 123 state resolutions were adopted; another 25 were amended and adopted; 27 were referred to the Board or to one or more councils; 22 were combined with one or more others into substitute resolutions; eight were replaced by substitute resolutions; and 14 were not adopted.

The will of the House was expressed on a great variety of subjects.

Therapeutic Abortion

One subject that has generated interest not only in the profession but among legislatures and the public is therapeutic abortion.

The House updated the Association's 1871 policy on the subject which, according to the reference committee report which was adopted, was not only antiquated but lacked even the rudiments of adequate safeguards to prevent abuse. The updated policy, the House agreed, is in keeping with modern scientific knowledge, contains necessary safeguards and permits the physician to exercise his personal conscience and medical judgment in the best interest of his patient, over-riding objectives in any medical decision.

The following was established as policy of the American Medical Association:

" . . . Recognizing that there are many physicians who, on moral or religious grounds, oppose therapeutic abortion under any circumstances, the American Medical Association is opposed to induced abortion except when:

"(1) There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother, or

"(2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

"(3) There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest may constitute a threat to the mental or physical health of the patient;

"(4) Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

"(5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

"It is to be considered consistent with the principles of ethics of the American Medical Association for physicians to provide medical information to State Legislatures in their consideration of revision and/or the development of new legislation regarding therapeutic abortion."

Health Care Cost

"Today . . . the ability of the physician to serve his patient is being handicapped by the rapidly rising prices of the various components of health care." That is a statement from the Board of Trustees report adopted by the House with the pro-

vision that it be widely disseminated for study and evaluation as to its applicability in local areas.

"Indeed," the report continued, "if the price of health care continues to outrun slower increases in consumers' income, the problem of medical indigency will assume alarming proportions."

Basic problems in the over-all design of the nation's health care system, as shown in the adopted report, include inadequate numbers of new physicians and shortages of other individuals trained to function as part of the health care team; the present organization and management of the nation's hospitals, with respect to their "privilege of automatically translating all higher costs into higher prices" which "must now be questioned;" diagnostic and therapeutic care outside of a hospital; and legislation in the health field.

A number of actions were taken to outline possible solutions to the problems of higher health care costs. One important one was the adoption of a progress report on strengthening and improving voluntary health insurance programs, submitted by the Council on Medical Service. The House accepted the Council's statements that it would "continue to study the scope and patterns of benefits, public demands for coverage, the performance of health insurance and prepayment programs and accumulation of data for future use;" and that the Council would "proceed to develop guiding principles for health insurance and prepayment programs."

As further efforts in this direction, the House referred to the Board and to the Council on Medical Service a resolution that the AMA "consult with insurers in an effort to change their policy of insurance coverage so that payment can be made for diagnostic procedures and minor surgery performed in the physicians' office and/or in the hospital outpatient department;" adopted a resolution that the Association petition congress to remove the restriction on first-dollar deduction from income tax laws for health care expenditures; and adopted the over-all policy that "physicians . . . continue to do everything possible to help the public conserve its health care dollars."

Government Health Programs

As might be expected, a great many reports and resolutions dealt directly or indirectly with the Association's relationships with government and with the multitude of government programs existing or proposed in the health field.

The House re-affirmed Association policy that "The medical profession has long and consistently held to two basic positions

concerning personal health care and its financing: that no one should go without needed care because of inability to pay, and that responsibility for payment rests first on the individual himself and then, to the extent that he is unable to pay, on his family, the community, the county, the state, and, to the extent that lesser levels of government are unable to finance the care, the federal government."

Regarding the Title XIX program, the House made it policy that "the medical profession should now take a firm stand in support of the Title XIX approach in improving the health and the delivery of health care services to the needy of the nation."

Recommendations adopted by the House are that the medical profession take a strong stand in support of implementation of Title XIX "while still seeking such changes in the federal legislation and/or regulations as will improve this program; that it urge organized medicine to take a leading role in formulating and directing Title XIX programs at the state and local level . . . and that it incorporate in such planning the use of existing voluntary mechanisms and private insurance carriers, wherever feasible, utilizing the usual and customary fee principle, thus bringing within the mainstream of present medical care systems the provision of quality health care for all Americans."

Appalachian regional health programs were the subject of a number of resolutions and the House adopted the following guidelines for setting up any such programs: (1) demonstrated need for the proposed project; (2) local control; (3) participation of a significant proportion of local physicians in planning and development of the project; (4) the operation of any regional, area or county health service facility shall not infringe upon the private practice of medicine; (5) all health services, whether preventive, prophylactic or therapeutic, shall be rendered at a cost to the patient commensurate with the social and economic status of the patient; (6) there shall be adequate medical representation on all national, state and local bodies having supervision or jurisdiction in the development and/or operation of such health service facilities; (7) these health service projects shall in no way be developed, operated or influenced in any manner which could lead to a government-controlled system of medical practice.

More generally, in connection with any and all government medical care programs, guidelines were adopted by the House:

"The medical profession in any community is best represented by the local medical society and its officers. They should be consulted initially, and during the process

of planning of any and all projects for the care of the sick and the preservation of health."

In proposing any new facility, "It shall be first determined that existing facilities are so inadequate that only a completely new facility will provide a solution.

"The responsibility for the health needs of a community basically resides at the community level, and all the local resources . . . shall be examined before the community accepts government monies.

"If it is deemed advisable to operate a government-financed facility in a community, it shall in no way be binding upon a physician to refer his patients there; to coerce a physician to service the facility; and this facility must in no way infringe upon the private practice of medicine.

"These projects should not be developed or operated in such a manner as to establish a precedent that could lead to a governmental controlled medical care system in this country."

Physician Control Over Collection and Disbursement of Professional Fees

In adopting a report of the Council on Medical Service regarding collection and disbursement of professional fees, the House reaffirmed past action and provided clear, consistent policy statements reflected in these thoughts which are elaborated in the full report:

1. It is proper for the physician to establish the fee he charges to any patient for professional service rendered, with the recognition that a duly constituted committee of his peers may appropriately review and pass upon the equity and justice of his charge.

2. It is proper for third party agencies to make payment of professional medical fees for patients.

3. It is proper for a physician to work with other physicians in a team approach to the provision of medical service, recognizing that each is entitled to compensation according to the value of his services and that charges attributable to each physician's service shall be made clear to the patient.

4. It is proper for a physician who provides personal supervision and direction for a physician-in-training to charge for the professional medical service rendered.

5. A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as the agent for him unless it is with the consent of the physician and of the medical staff.

6. Physicians, collectively in hospitals, may properly establish special medical staff funds, wholly under their own control, which they may support as they see fit,

disburse as they may agree.

7. Fees for professional medical services are properly paid only to the responsible physicians and may not be appropriated by any other person or agency.

8. The physician is the sole arbiter as to ways he may dispose of his professional income, without duress, consistent with the laws of the land and the Principles of Medical Ethics of this Association.

Millis Commission and Commission on Research

Because the contents of the Millis Commission report (Citizens Commission on Graduate Medical Education) relate so specifically to the roles of the Councils on Medical Education and Medical Service, the two councils have assumed responsibility for assembling critiques and information. At a later date, they will bring to the Board, and subsequently to the House, recommendations for implementations of parts or the whole of the report. The House urged all interested members of the Association or groups to submit comments, suggestions or recommendations for consideration by the two councils.

With respect to the Commission on Research, the Board has established a Committee on Research to review reports on the subject from the Councils on Medical Education and Medical Service; refer portions of the report to other councils and committees; and confer with those groups in addition to receiving their reports.

Again, the House urged any interested individuals and groups to forward comments and suggestions to the Executive Vice President for transmittal to the committee.

Medicine and Osteopathy

The House adopted the following recommendations of the Board regarding the medical profession's relationships with osteopathy:

1. Authorize the Board of Trustees to begin promptly negotiations directed toward beginning official change of schools of osteopathy to schools of medicine. (It is understood that from the American Medical Association funds will be required to conduct these negotiations, and assistance in identifying and securing additional funds from other sources to support efforts toward changing the schools.)

2. Authorize the Council on Medical Education to undertake negotiations to establish means by which selected students with proven satisfactory scholastic ability in schools of osteopathy may be considered by schools of medicine for transfer into medical school classes.

The primary issue in the relationship of medicine and osteopathy, as recognized by

the House, seems to be not that of cultism as opposed to science. Rather the issue appears to be one level of medical education and practice as opposed to another and lower level of education and practice. The extensive and growing licensure of osteopathic physicians for the unrestricted practice of medicine and the nature of osteopathic education strongly indicate that time alone will resolve shortly the problem of cultism in relation to osteopathy.

Medical Manpower

The House accepted for information a report from the Board which pointed out that "The production of well-qualified physicians in adequate numbers is necessary to meet effectively both social and economic demands for health care." It reviewed some of the activities of the Committee on Health Manpower and concluded that "The AMA should continue to study the effect of new roles for health personnel and new interrelationships and interdependencies between health professionals, as well as the impact of innovative concepts on the organizational structure evolving in the general system of health care delivery. . . .

"In any event, our resolve should always be as it is now: to use the best tested and most forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated and highly skilled physicians."

The House also referred to the Board, for consideration by the committee, a resolution that "deliberations include strong emphasis on sound ways of accelerating medical education in all its phases, including post-MD and graduate education, and of increasing the supply of physicians in all categories."

In addition, the House adopted reports calling for revision of the Essentials of Approved Residencies in radiology, obstetrics and gynecology; adopted a resolution calling for the promotion of better practices in inhalation therapy; and adopted a resolution that the AMA reaffirm its support of all forms of nursing education; that hospitals which conduct diploma schools of nursing be commended; that such hospitals be urged to continue their schools and increase enrollment; and that the AMA take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools and at the same time improve educational standards.

Committee on Planning and Development

At the June, 1966, convention of the House, the Board announced the appoint-

ment of a committee to study planning and development techniques within the Association. The report of the committee was received and the Board submitted its final report to the House at this convention.

The Board voted to (1) establish a permanent Committee on Planning and Development and (2) select seven active members of the AMA as members. The following charges were established for the committee:

1. Study and make recommendations concerning the long-range objectives of the Association and the resources, programs and organizational structure by which the Association attempts to reach them.

2. Serve as a focal point for the planning activities of the Association and stimulate and coordinate planning activities throughout the organization.

3. Study, or cause to be studied, medicine and the environment in which the Association must function and transmit the conclusions of these studies to the Board.

In the report adopted by the House, the Board earnestly solicited nominations to the committee from delegates, constituent associations, component societies and other interested groups and individuals.

Two resolutions on the subject were referred to the Board.

It is noteworthy that in his report to the House, President Rouse stated that "We now have an established Committee on Planning and Development at the AMA level. I hope that every county and state association will likewise make use of a comparable committee, to plan wisely and develop properly the policies and programs needed in the decades ahead — far beyond just the next year."

Members' Disability Insurance Program

The House adopted the report of the reference committee on this subject, and referred to the Board a number of resolutions pertaining to it.

The committee's report, as adopted, recommended that the House authorize the Board to make every effort to continue the AMA Members Group Disability Insurance Program with the same premium-benefit structure. It also recommended the following guidelines to aid the Board in negotiating and executing the necessary contracts and in the future operation of the program:

1. The contract should provide ample assurance that disability claimants will be treated equitably and justly.

2. The carrier should guarantee benefits and premiums for a period of at least five years in order to assure the stability of the program.

3. Promotional literature should be ap-

proved in advance by the Board or its designee. All measures within the bounds of dignity and ethics should be utilized to promote the program.

4. A continuous ongoing review of the entire program should be maintained. The insureds and other members should be made aware that such a review may reveal in the future the necessity for a revision of the program at the end of the five-year period.

5. Information regarding the operation of the program, its financial aspects and the processing of claims should be available to the Board for review at any time.

6. An AMA Disability Insurance Review Committee should be continued and should provide a mechanism for claims review.

Political Action

Several resolutions were offered to the House questioning whether the administration of government programs is truly carrying out the intent of Congress in its passage of laws. They were combined by the House into one resolution stating "That if legislation is introduced to investigate the activities of the Department of HEW and its executive personnel who are concerned with health matters to determine if the intent of Congress is being carried out, the American Medical Association will provide to such an investigation any information that its Board and councils may secure in these matters."

The resolution also pointed out that since the most effective method to preserve the private practice of medicine is to elect proper officials at all levels of government, "the American Medical Association urges that physicians, as individuals, re-double their efforts in political activities."

It was also resolved that the Association "continue and expand its efforts to inform our membership of its activities to represent them, particularly before the Congress and the federal agencies."

The House also adopted a resolution "That medical societies be urged to investigate, document and report to the Law Division . . . all violations of Public Law 89-97 by officers or employees of the federal government" and that "a status report be provided to this House at the 1967 Clinical Convention."

The House also reaffirmed the Association's opposition to S. 260 (the Hart Bill) and its support of direct billing under Part B of Medicare on the basis of a physician's itemized statement of charges.

The House supported AMPAC and the state PAC organizations by adopting a resolution recognizing "that leadership at all levels of medicine should make individual commitment to state PAC-AMPAC membership and local PAC programs, wherever this is legally possible."

Generic Prescribing

A resolution combining several state resolutions was adopted by the House, asserting "that the AMA again reaffirm its policy that physicians should be free to use either the generic or the brand names in prescribing drugs for their patients; and encourage physicians to supplement medical judgments with cost considerations in making this choice."

Other Actions

During the convention, the House welcomed 15 physicians who have served in the Volunteer Physicians for Vietnam program; conducted a memorial service for 27 members of the House and/or officers of the Association who had died since the 1965 Annual Convention; heard a report on AMPAC from Blair J. Henningsgaard, M.D., chairman of the AMPAC board; heard a report on AMA-ERF from Immediate Past President James Z. Appel, M.D., President of AMA-ERF; permitted a representative from the Oregon Woman's Auxiliary to introduce to the House the "Doctor's Wife," a new rose developed by the Oregon auxiliary; and heard a talk by David Kindig, president of the Student American Medical Association.

Adopted many other resolutions, including these:

Amending the bylaws so that recipients of the Distinguished Service Award and the Citation of a Layman for Distinguished Service will be nominated at the Clinical

Convention and the presentations will be made at the next Annual Convention.

Confirming that there is nothing in the military officers' oath that conflicts in any way with the ethics of the medical profession.

Noting that a double standard of policy often exists between so-called "hospital-based specialists" and other types of practitioners with respect to hospital staff appointments and endorsing "the principle of a single standard with respect to staff appointments among all physicians having equivalent credentials in all hospital departments and services as a means of assuring maximum freedom of choice of physicians by patients, and of consultants by staff members."

Requesting the JCAH to "encourage . . . the acceptance, wherever possible of physicians elected or appointed by the medical staff to the Board of Trustees with full voting rights as the most effective form of liaison between the medical staff and hospital governing authorities."

Opposing the establishment of a racial quota system for hospitals.

Encouraging farm equipment manufacturers to establish standards for basic overturn protective frames and crush-resistant cabs.

Reaffirming the Association's policy regarding tobacco and health and promising vigorous continuation of its measures for corrective action.

Urging that disposable hypodermic

syringes be thrown away in such a way as to prevent their possible re-use.

Encouraging state associations to inform state legislators of the need to re-examine existing "battered child" laws so child abuse is to be reported by physicians as well as medically oriented social services.

Supporting continued research and control measures for venereal disease.

Reaffirming the Association's opposition to requirements for certification and recertification.

Stating the Association's continuing concern for the prevention of death and injury from burns by "stepping up its education campaign to make the public more aware of the dangers inherent in flammable fabrics and other related flammable materials" and resolving that "the AMA cooperate with other voluntary associations in the furtherance of this program."

Finally, the House welcomed as its guests at the opening session the winners of the AMA's top awards at the 18th International Science Fair, held in San Francisco. They were Susan T. Bertrand, New Albany, Ind., whose exhibit was "Electrophoretic Analysis of Blood Serum;" and Stephen R. Igo, Winterset, Iowa, with an exhibit showing the design, construction and operation of a small, synchronous intrathoracic auxiliary ventricle. Both winning exhibits were on display during the convention.

GUY A. OWSLEY, M.D.

JACK E. SHIELDS, M.D.

HAROLD C. OCHSNER, M.D.

EUGENE F. SENSENY, M.D.

FRANK H. GREEN, M.D.

Reports of Committees

Executive Committee

Your committee met for the first time on October 13th, following adjournment of the final meeting of the House of Delegates and the Council, for the purpose of reorganization of the committee. By secret ballot, Dr. Ralph V. Everly was elected chairman of the Executive Committee for the year 1966 and 1967. Also at this meeting Dr. Burton E. Kintner, of Elkhart, and Dr. Lowell H. Steen, the new chairman of the Council were welcomed as members of the Executive Committee.

The committee met again on October 30th at the Columbia Club for the purpose of an informal discussion with Judge Ralph Hamill concerning some of the public relations activities of the association and some of the problems of the I-HOPE organization. Also discussed at this meeting was a modification of the Dependents Medical Care Program, covering the expanded program which became effective on October 1, and further expansion to take place on January 1, 1967. By action properly taken the president was authorized to sign these modifications for the association.

Copies of the minutes of all meetings of the Executive Committee have been given to the reference committees for their review. We shall attempt to highlight some of the activities of your Executive Committee taken during this past year.

The committee met in regular session on November 19, 1966 with the full attendance present.

At this meeting a discussion of the proposed implementation of Title XIX in the state of Indiana and the matter of handling welfare cases under Title XVIII were thoroughly discussed. Also was a letter from the American Medical Association concerning the necessity of their curtailment of loans to medical students. This was referred to the Committee on Student Loans, for their information and action.

The association was also informed of the plaques to be awarded to the Indiana physicians who had volunteered for service in Viet Nam and action was taken to refer this presentation to the Council with recommendation that the plaques be awarded during the January Council meeting.

Also at this meeting the committee took steps to refer to the Council a letter from Ralph Hamill, attorney, concerning the proposed suit against Blue Cross.

Many matters concerning the new Medicare program were discussed at the January 21st meeting; among them being the correspondence between the headquarters office and various departments of the Social Security Administration dealing with assignments in welfare cases. Also the secretary presented a draft of the proposed report of the AMA Council on Medical Services of the American Medical Association and their intended definition of "usual and customary." All of these various matters dealing with this subject were referred to the Council for their action.

The Executive Committee met with Mrs. John Deever and Mrs. Alfred Scales, president and president-elect of the Woman's Auxiliary to the Indiana State Medical Association, for the purpose of reviewing the auxiliary program for the coming year and for the purpose of assigning various tasks to the auxiliary for the coming months. Also the committee received a request from the auxiliary for financial assistance in the amount of one thousand dollars to assist them in carrying on these activities. The request was granted.

At this meeting, the treasurer presented the annual audit by the George S. Olive Company which was reviewed and approved by motion of Drs. Larson and Steen. The committee also took action to make the final payment on the headquarters building and to refer the association investment portfolio to the Council Committee on Fiscal Matters.

The committee had called to its attention the action in the Congress concerning the word "prevailing" and by actions taken, the committee took the position of defining "prevailing" as synonymous with "usual and customary" as it relates to the individual physician's practice and not to the community.

The financial proposal of Judge Hamill for handling the litigation on the transfer of professional services from Blue Cross to Blue Shield was received and referred to the Council for their action.

Also referred to the Council was correspondence between the secretary's office and the Social Security Administration concerning the handling of welfare cases with an alternative to the assignment basis.

The plan of the federal government on student loans and also their compilation of physician shortage areas in the state of Indiana were reviewed, as were the requests of several of the commissions of the association.

The committee was also made aware of the actions of the Board of Trustees of the American Medical Association as well as the action of the Lake County Medical Society in approving the use of the bank

credit card plan in their county society.

The editor of *The Journal* was given consent by the committee to take steps to raise the advertising rates in *The Journal*.

The Executive Committee sitting as the budget committee as provided for in the Constitution and Bylaws met on January 21, along with the members of the Council Committee on Economic and Fiscal Matters for the purpose of preparing the budget for the 1967 fiscal year. The budget was approved, section by section, and referred to the Council for their endorsement.

On February 25, 1967, your committee convened with full attendance for the purpose of hearing Mr. Richard C. Kilborn and Dr. Glen V. Ryan discuss several matters relating to the Blue Shield program in the state of Indiana. The first was the request for approval of the association to permit Blue Shield to apply for the contract as administrator of the Title XIX law when implemented in the state of Indiana. The request was approved. Next Dr. Ryan stated that the Blue Shield Board had been discussing changing several titles, changing his from president to chairman of the board and Mr. Kilborn's title of executive vice-president would be changed just to president. This was discussed quite thoroughly and finally the committee approved the changing of titles if so approved by the board of Blue Shield.

The committee completed plans for a meeting with Dr. F. J. L. Blasingame, executive vice-president of the American Medical Association, which was to be held in the association headquarters office on March 1.

The committee had called to its attention several matters currently pending before the Congress, particularly Public Law 89-749 and also a memorandum from the AMA concerning the Health Manpower program. These matters were referred to the Commission on Public Health, the Commission on Governmental Medical Services and the Commission on Legislation for their information.

The secretary brought to the attention of the committee the involvement of medicine in many of the federal programs and the lack of adequate manpower for coping with some of the programs now confronting medicine and asked approval for the employment of another person to head up a department on research and planning in the federal health field, as it relates to the medical profession. The secretary was instructed to attempt to employ an individual for this purpose.

Note was made that Dr. Otis Bowen is the fourth physician to be honored by election as Speaker of the House of Representatives in the state of Indiana. A specific proposal for increasing the adver-

tising rates in *The Journal* was reviewed and approved.

In addition to these few notations, many routine matters of housekeeping were handled as well as requests of individual physicians, committees and commissions of the association.

Your committee convened again at 4 p.m. on March 18th with full attendance and handled the usual routine matters which normally come before the committee. The insurance company settlement on the boiler was approved and the secretary discussed many matters which occurred in the last session of the State Legislature, including the passage of House Bill 1420 and the Governor's veto of the bill to implement Title XIX.

The committee reviewed the arrangements with Continental Casualty Company concerning coverage of Indiana physicians. Also discussed was the AMA's disability program, on which Dr. Bibler had recently reported the action of the Board of Trustees.

The committee also discussed the report of the Future Planning Committee and took action to recommend to the Council that the Council meet more frequently than four times per year.

The committee also thought that the association should make an effort in the future to invite allied technical groups such as the Indiana Association of Radiological Technicians to meet jointly with the association at state conventions. Such a recommendation has been made to the convention arrangements committee.

The meeting of April 8th, 1967, aside from the usual routine matters that normally come before the committee for their dispersal, the secretary reported on Senate Bill 1366 on the handling of drugs under title XIX. And also the proposed Social Security Amendment covered in HR-5710. Also discussed was Senate Bill 359 adopted by the Indiana General Assembly, known as the "Indiana Plan." By consent, three physicians were recommended to the Governor for his consideration and appointment to this new committee.

Activities in the state of Indiana with areawide planning programs came in for a full discussion, and as a result, the committee referred to the Council a recommendation that the Council authorize the president to appoint an Ad-Hoc Committee to deal with the subject of areawide and comprehensive health planning.

The committee noted there were six(6) district meetings scheduled for the same day. It was agreed that this should be called to the attention of the Council and recommended that the Council take steps to establish district meeting dates so as to

avoid this problem, which prevents the officers of the association from being present for these important meetings.

The committee interviewed potential new employees at the June 10, 1967, meeting to handle the Department on Research and Planning and heard a report from the secretary on his visit to the Military Dependents Care Program in Denver, Colorado. The committee also took action to further reduce the indebtedness on the Pennsylvania Street property with a payment of \$7,500 on the principal of that loan.

The committee also received a gift of \$1,200 from the Woman's Auxiliary as a contribution to the Kitchen Fund of the association. The committee noted the auxiliary has been most generous for the past several years, helping to defray the expense of further improving the facilities of the association headquarters. Certainly this House of Delegates should extend to the auxiliary their sincere thanks for the valuable contributions they have made to this effort.

Many routine organization matters were also handled and these are detailed in the copies of the minutes in the hands of the reference committees. They have also been published in *The Journal of the Indiana State Medical Association*. Among the many things the secretary called to the attention of the committee were that the American Medical Association had taken no action, at this time, in filing an objection to the policy statement in the Public Assistance Handbook, which policy would have the effect of preventing a physician from dispensing drugs and being reimbursed for them under title XIX. The secretary was instructed to draft a resolution for submission at the AMA meeting in June.

Routine matters were dispensed with in orderly fashion at the meeting of July 29, 1967, and a letter from Judge Hamill indicated the Marion County Tax Board had denied a tax exemption for personal property and real estate for the year 1966, payable in 1967. This matter is in the courts at the present time and an appeal is being made to the court on this ruling.

Attention was called to the activities of the State Department of Public Welfare requiring doctors to sign a form on which was printed a compliance statement with the Civil Rights Act. This matter was discussed thoroughly and the secretary was requested to take steps to seek the removal of this requirement from the state welfare program.

The committee received a communication from the AMA, in which they pointed out they had transmitted the Indiana resolution objecting to the policy statement

known as D-5150, which is the clause prohibiting a physician from being paid for drugs dispensed under title XVIII and XIX to the Department of HEW in Washington, D.C.

Medical Defense Activities

1. *Malpractice Cases.* A year ago, at the time of this report, August 1, 1966, the following two cases were pending before the committee:

Case No. 307—Suit filed March 22, 1962. Pending. (Expense to date, \$1,042.73).

Case No. 309—Suit filed December 10, 1964. Pending.

Since August 1, 1966, and up to August 1, 1967, the following new case has come before the committee, making three cases pending at this time as against two unclosed cases at the same time last year:

Case No. 310—Suit filed August, 1966. Pending. (Expense to date, \$4,532.03).

2. *Medical Defense Fund Statement from August 1, 1966, to August 1, 1967:*

Bank balance, August 1, 1966 ...\$ 410.34
Receipts:

Dues	\$4,930.75	
Interest	975.00	
Treasury Bills		
matured	5,000.00	
Advance from		
General Fund ...	2,300.00	13,205.75
Total receipts		\$13,616.09

Disbursements:		
Attorney's retainer	\$6,296.25	
Reimbursement for		
legal defense ...	5,574.76	
Total disbursements		11,871.01

Balance on hand,
August 1, 1967\$ 1,745.08

MEMBERSHIP REPORT

	Dec. 31, 1966	July 31, 1966	July 31, 1967	AMA, 1967
1st District				
Gibson	14	13	13	13
Perry	8	8	8	8
Pike	4	4	3	3
Posey	8	8	8	8
Spencer	4	3	4	3
Vanderburgh	234	229	232	228
Warrick	7	7	7	7
TOTAL	279	273	275	270
2nd District				
Davies-Martin	19	19	21	10
Greene	14	14	13	7
Knox	41	40	41	38
Owen-Monroe	69	68	72	70
Sullivan	14	14	13	12
TOTAL	157	155	160	137

MEMBERSHIP REPORT

	Dec. 31, 1966	July 31, 1966	July 31, 1967	AMA, 1967
3rd District				
Clark	43	41	40	38
Dubois	21	21	23	17
Floyd	39	39	39	38
Harrison-Crawford	10	10	11	11
Lawrence	25	25	25	23
Orange	9	9	9	9
Scott	5	5	5	5
Washington	7	7	7	7
TOTAL	159	157	159	148
4th District				
Bartholomew-Brown	50	50	51	49
Dearborn-Ohio	20	20	17	15
Decatur	10	10	9	8
Jackson-Jennings	24	24	25	21
Jefferson-Switzerland	29	29	23	21
Ripley	9	9	8	6
TOTAL	142	142	133	121
5th District				
Clay	12	12	14	14
Parke-Vermillion	23	23	22	22
Putnam	17	17	15	13
Vigo	116	116	113	113
TOTAL	168	168	164	162
6th District				
Fayette-Franklin	15	15	16	16
Hancock	23	23	22	22
Henry	34	34	38	39
Rush	15	15	15	15
Shelby	19	19	19	17
Wayne-Union	68	66	70	68
TOTAL	174	172	180	177
7th District				
Hendricks	20	20	20	20
Johnson	29	28	30	30
Marion	1067	1065	1053	1047
Morgan	20	20	20	19
TOTAL	1136	1133	1123	1116
8th District				
Delaware-Blackford	117	117	118	111
Jay	15	15	16	13
Madison	103	103	103	71
Randolph	20	20	19	16
TOTAL	255	255	256	211
9th District				
Benton	8	8	8	8
Boone	19	19	21	20
Clinton	20	20	20	20
Fountain-Warren	14	14	14	14
Hamilton	20	20	18	13
Montgomery	27	27	23	22
Newton	5	5	5	5
Tippecanoe	132	128	134	130
Tipton	11	11	11	11
White	11	11	10	10
TOTAL	267	263	264	253
10th District				
Jasper	9	7	7	7
Lake	437	423	418	387
Porter	44	43	43	43
TOTAL	488	473	468	437
11th District				
Carroll	9	9	8	8
Cass	32	32	32	25
Grant	67	66	69	68
Howard	73	73	70	70
Huntington	22	22	21	21
Miami	14	14	11	11
Wabash	28	28	27	27
TOTAL	245	243	238	230
12th District				
Adams	14	14	15	15
Allen	296	294	292	286
De Kalb	23	23	23	23
La Grange	7	7	9	9
Noble	16	16	16	16
Steuben	13	12	13	13
Wells	43	40	47	47
Whitley	17	17	17	17
TOTAL	429	423	432	426

13th District				
Elkhart	108	108	111	109
Fulton	11	11	10	9
Kosciusko	16	16	17	17
La Porte	101	101	96	89
Marshall	26	26	25	25
Pulaski	6	6	5	4
St. Joseph	236	236	234	233
Starke	6	6	6	6
TOTAL	510	510	504	492
SUMMARY				
1st District	279	273	275	270
2nd District	157	155	160	137
3rd District	159	157	159	148
4th District	142	142	133	121
5th District	168	163	164	162
6th District	174	172	180	177
7th District	1136	1133	1123	1116
8th District	255	255	256	211
9th District	267	263	264	253
10th District	488	473	468	437
11th District	245	243	238	230
12th District	429	423	432	426
13th District	510	510	504	492
TOTAL	4409	4367	4356	4180

The Journal

The report of *Journal* activity in advertising, for the first time in several years, can be posed in optimistic terms. After several years of serious losses, it appears that between the economy in printing and the increase in advertising, it is going to place *The Journal* program in the black. Advertising revenues the first six months of 1967 are about \$6,000 ahead of last year.

This is a comparative report for the first six months of each year indicated.

	1964	1965	1966	1967
State Journal Advertising Bureau	\$13,474.13	\$13,927.88	\$18,069.54	\$23,468.96
Sold Direct by Journal	2,017.10	2,812.74	2,687.76	3,056.68
Total	\$15,491.23	\$16,740.62	\$20,757.30	\$26,525.64

Printing Costs

Year	Cost	(Inserts excluded) No. of Pages
1963	\$44,212.23	1612
1964	36,139.47	1456
1965	35,957.50	1416
1966	41,795.32	1410
1967 (6 months)	24,450.86	716

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. Pages per Issue
1961	1284	67	634	33	1918	160
1962	1308	68	604	32	1912	159
1963	1139	70	487	30	1626	135
1964	1051	71	423	29	1474	123
1965	998	68	464	32	1462	122
1966	789	50	781	50	1570	131

RALPH V. EVERLY, M.D., *Chairman*
BURTON E. KINTNER, M.D.
EUGENE S. RIFNER, M.D.
G. O. LARSON, M.D.
LOWELL H. STEEN, M.D.
OTTIS N. OLVEY, M.D.
LESTER HOYT, M.D.

Grievance Committee

The Grievance Committee held meetings on October 30, and November 20, 1966 and July 30, 1967.

As of July 30, 1967, eight complaints had been considered during the preceding twelve months. Of this number seven were accepted as cases with the usual sequence of referral, first to the physician against whom the complaint was lodged, second to his county society and lastly, should both either fail or decline to attempt the adjudication, back to the ISMA Grievance Committee for an effort at settlement. Out of seven cases referred to the physician, three were settled at that level. Out of two cases handled through the county society grievance channel, one was adjudicated and one is pending. One complaint was automatically closed because of legal action; one complaint was referred to the Council of ISMA which in turn sent it back to the county medical society; one complaint is still pending. Of the 12 cases pending as of July, 1966, eleven have been closed, leaving one pending which was referred to the county medical society. In summary, 17 of the 19 cases accepted by the Grievance Committee in the two years ending July 30, 1967, were adjudicated during the last year with the two remaining cases now pending county society action.

The ISMA Grievance Committee voted at its July 30 meeting to request that the attention of every ISMA member be called to the increasing number of charges brought against physicians, principally through failure to acquaint the public with the individual physicians as well as local group or hospital staff arrangements for the care of presumed medical emergencies. With a continuing shortage of physicians, complaints can only be expected to multiply unless more emergency plans are made known and kept workable. The investigations demanded of the Grievance Committee disclosed several recurring foci of growing public resentment. These foci were: The telephone answering attitude of hospitals or the physician's office personnel or even those answering in the physician's home or that of one covering for him. Reports reflected the impression that those answering had not been sufficiently informed, had forgotten or, under the emotional pressure of the moment, had ignored certain basic facts.

a. That the average caller who believes that he, or the one for whom he feels responsible, is critically in need is reacting not at his chronologic or his mental age but at his emotional age and the higher the stress of the moment, the lower the emotional age.

b. That the average caller is uninformed as to the physician's or hospital staff's plan for caring for individual emergencies. Several complainants have cited an indignant or condescending tone which infers the caller is stupid if he asks a second question as to procedure, which the informant assumed should be generally known.

c. That the average caller indicts all of medicine, at least in his community, when his good faith emergency call results in what he variously describes as a vague, confusing, contradictory or rejecting response.

A second cluster of complaints center around what patients describe as the indifferent or resentful behavior of hospital emergency room or physician's office personnel. In most instances the patient hopefully anticipates emergency treatment upon arrival only to be told to sit down and wait with little or no effort to determine the seriousness of his problem. As one complainant put it, the patient should be able to expect in a hospital or a doctor's office at least a Girl Scout level of both courtesy and first aid when a physician is not available at the moment.

The third group of complaints are the result of the physician's own response on the telephone or his personal handling of the case which, fortunately for the Grievance Committee, is less often the basis for complaint but when it does occur, the charge is obviously far more critical for all who practice medicine. It may be significant that when the physician is criticized, the complainant usually remarks upon the same attitude present in those answering his telephone or working with him.

The Grievance Committee while recognizing its fact-gathering and information disseminating responsibility also believes that it lacks the authority, the manpower and the budget to do more than recommend to the House of Delegates the need for a program to locally circulate information in many communities as to current arrangements for emergency care and to possibly upgrade this care in a few localities in Indiana. Certain communities with fewer physicians have individually and collectively organized a plan for handling medical emergencies which results in no complaints or in the solution of complaints at the local level.

The Grievance Committee requests authorization and funds for the rewriting and printing of the first revision of the 1952 version of Purposes, Rules and Procedure of the Board of Appeals on Patient-Physician Relations (The Grievance Committee). The 1952 booklet lost its proper designation of references as the Constitu-

tion and Bylaws of the Indiana State Medical Association has gone through its several revisions in the 19 years that have elapsed. It is further requested that one copy of the up-dated booklet be mailed to every present member of the ISMA and that each incoming member receive a copy with an accompanying letter signed by the president of the association and the chairman of the Council as provided by paragraph 5 on page 15.

In concluding this report the Grievance Committee wishes to thank the members of the ISMA who have been called upon to assist us in discharging our responsibility. With few exceptions we have received excellent help.

PHILIP B. REED, M.D., *Chairman*
MARVIN L. McCLAIN, M.D.,
Vice-Chairman
ROBERT G. YOUNG, M.D., *Secretary*
EARL W. MERICLE, M.D.
GUY A. OWSLEY, M.D.
WILLIAM R. CLARK, M.D.
MAURICE E. GLOCK, M.D.
HUGH B. McADAMS, M.D.
WILLIAM R. NOE, M.D.
KENNETH L. OLSON, M.D.

Student Loan

The Student Loan Committee held four meetings during the past year. The committee interviewed 11 students, all of whom were granted loans, for a total of \$9,900.00.

Under the Guaranteed Loan Plan with the Indiana National Bank, which was instituted December 1, 1963, the association has on deposit with the bank \$20,810.00 to guarantee loans totaling \$260,125.00. As of July 31, 1967, 70 loans, totaling \$58,900.00, have been granted under this plan.

A report on the Loan Fund which was under association management from October, 1955, to December 31, 1963, follows:

Total loaned to 117 students \$58,458.36
Total repaid by loanees as
of July 31, 1967 49,289.10

Total amount outstanding, July 31, 1967 \$9,169.26

Of the 117 who received loans,
92 have repaid in full
* 18 are making payments (\$6,719.26)
* 7 have made no payments (\$2,450.00)

* Total due on above 25 loans still outstanding \$9,169.26 (\$1,450.00 of the above \$9,169.26 is for loans which just became payable on July 1, 1967.)

It will be noted that 18 physicians are making payments and seven have not started payment. The committee is making

every effort, with the assistance of Mr. Hollowell, attorney, to collect these unpaid accounts, some of which are overdue.
LESTER D. BIBLER, M.D., *Chairman*
GLENN W. IRWIN, M.D., *Vice-Chairman*
ROBERT HOLLOWELL, *Secretary*
EUGENE S. RIFNER, M.D.
OTTIS N. OLVEY, M.D.
JAMES O. RITCHEY, M.D.
P. J. V. CORCORAN, M.D.

Future Planning Committee

The Future Planning Committee of the ISMA met in the Headquarters of the Indiana State Medical Association, on Sunday, February 19, 1967.

At that time several matters of importance were discussed, including:

1. Activities of the Legislative Commission of the Indiana State Medical Association.
2. Problems of district medical societies.
3. The possibility of adding two field men to the staff of the Indiana State Medical Association.
4. Discussion of the commission structure of the Indiana State Medical Association.
5. The need for better liaison and communication between the commission and the Council of the ISMA.

In the discussion of the activities of the Legislative Commission of the ISMA it was generally expressed that this commission, while it does an unusually effective job of over-seeing legislative issues in the Indiana General Assembly, does not become deeply involved in the legislative processes at the national level. The Future Planning Committee recommends that the Legislative Commission of the ISMA henceforth concern itself with increased intensity with legislative issues at the national level and keep the membership of the ISMA more closely advised.

In discussion of problems of the district medical societies, the Future Planning Committee decided to hold a meeting in June, 1967, at which time district society officers would be invited to a meeting in the headquarters office of the ISMA to frankly discuss the problem of attendance and programming for districts. Response to the meeting was inadequate and the meeting was subsequently postponed.

In lieu of the meeting, however, a questionnaire was circulated by the Future Planning Committee to district societies and the survey was answered by six of the 13 districts. The Future Planning Committee is adding the results of this survey to this report and submits it as a part of this report, without recommendation, to be

acted upon by the House of Delegates of the association.

In discussing the possible need for two more field men, the Future Planning Committee however adopted the point of view that two more field men would permit more visitation to county societies and would give the field men more time to assist the membership in organizing both county society and district meetings more effectively.

In discussing the commission structure of the Indiana State Medical Association, it was again pointed out that the initial intent of the commission organization was to have each representative commission member act as a liaison person with the county medical society representative on similar committees in his district; and that it would be extremely well advised for these commission members to meet at least once a year with their district society colleagues who are involved in the same fields of interest. The purpose would be to examine problems, and exchange ideas of common interest for the dissemination of facts and information between county and state societies.

It was also felt by the Future Planning Committee that serious consideration should be given by the Council of the ISMA to extending the length of time for its meetings. This recommendation was based on the fact, after review of Council activities, that the Council does not have time enough now to adequately consider the projects and programs of the commissions. More time should be given to the commission chairmen for reporting to the Council and receiving Council opinions on programs which are being undertaken.

In addition the Future Planning Committee feels that perhaps the district society meeting should place less emphasis on matters of scientific and medical import at district meetings since scientific material is substantially disseminated through the convention of the ISMA and through the various specialty societies of organized medicine today. More emphasis should be placed on socio-economic-legal problems. With the emphasis in this area, better attendance could be achieved by inviting speakers to district society meetings who are professional in these areas and who could impart to the physician membership of the ISMA observations of import and medical concern.

It was also emphasized that district societies should inform themselves through appropriate programming of community health services now being developed at the federal level for local adaptation. Specifically mentioned were such programs as the Cancer, Heart Disease, and Stroke programs, which are and will affect the in-

dividual practitioner. The Future Planning Committee, of course, is aware that a new employee has been added to the staff of ISMA, with specific responsibilities in areawide planning and other federally proposed programs. The committee is also aware of the fact that a Council Committee for the Study and Implementation of Governmental Medical Programs is also functioning, and feels that such effort emphasizes more specifically the need for district societies, at their annual meetings, to plan programs in these areas.

SUMMARY: FUTURE PLANNING COMMITTEE SURVEY ON DISTRICT ORGANIZATIONS

Number of Districts Answering Survey—6

1. How can we improve communications between the district societies and the state office?
 - a. We of the 12th District feel that with our good councilor and alternate councilor we have adequate communication.
 - b. Contact councilor instead of officers.
 - c. Field secretary.
 - d. Hiring of executive secretary to work with the councilor and component societies.
2. How can we improve communications between the district societies and their members?
 - a. Newsletters from councilors.
 - b. Councilor to contact component county societies, or visit them.
 - c. Hiring of executive secretary. Institution of combined meetings of component societies on rotating basis.
3. Can the state association be of assistance?
 - a. In promoting the meetings—4 yes, 1 no
 - b. By supplying a packaged program—2 yes, 4 no
 1. Scientific 1
 2. Socio-Economic 0
 3. Medico-Legal 0
 4. Combination 0
 - c. By establishing the date for the meeting—4 yes, 1 no
 - d. By making the arrangements for the meeting, such as location, facilities, etc.—0 yes, 5 no
 - e. By increasing state dues \$5.00 to be

returned to the districts for expenses of the meeting—0 yes, 5 no

4. Can the field secretaries be helpful? 3 yes, 2 no
If "Yes" — How?

1. Personal contact in county society meetings.
 2. By attending meeting, by functioning as co-chairman for arrangements.
5. Other suggestions:
 - a. We feel that the district society is only as strong as its councilor. We have been blessed with good councilors and have kept the component societies informed — one-eighth to one-fourth of our membership attends annual meetings.
 - b. Resolutions to state society should be approved by the district society before submission by county societies.
 - c. Suggestions discussed without decision, but favored by many, to hold various district meetings at the time of the annual state meeting. Provision for this to be made by the program committee.
 - d. The Eighth District will hold a meeting of county presidents and delegates at the state meeting in the fall to determine the format of the Eighth District Meeting next year. Officers from Anderson were elected for next year, and they will probably contact the state society about help for the next year's program.

EARL W. MERICLE, M.D.,
Chairman

MAURICE E. GLOCK, M.D.

JAMES S. FITZPATRICK, M.D.

A. WAYNE RATCLIFFE, M.D.

FRED S. CARTER, M.D.

WILLIAM B. CHALLMAN, M.D.

JAMES E. WENGER, M.D.

CHARLES F. GILLESPIE, M.D.

LESLIE M. BAKER, M.D.

EUGENE S. RIFNER, M.D.,

Ex-Officio

G. O. LARSON, M.D.,

Ex-Officio

LOWELL H. STEEN, M.D.,

Ex-Officio

RALPH V. EVERLY, M.D.,

Ex-Officio

FRANK B. RAMSEY, M.D.,

Ex-Officio

Report of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws has had several matters referred to it for consideration and makes the following recommendations for changes in the Bylaws:

Be it resolved that the first sentence of Chapter VII, Section 1 of the Bylaws be amended to read as follows:

"Section 1. The Council shall meet as follows: 1. The Council shall meet at least once in each quarter of the calendar year; the time, date and location to be fixed by the Council." The remainder of Section 1, Chapter VII remains unchanged.

AMENDMENTS TO CONSTITUTION

Be it resolved that the first and second sentences of Article VI of the Constitution be amended to read as follows:

"ARTICLE VI-BOARD OF TRUSTEES

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) *ex-officio*, the President, President-elect, Treasurer with power to vote and Assistant Treasurer without power to vote except in case the Treasurer be absent. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all the property of the Association."

The balance of the Article to remain unchanged.

Be it further resolved that the following amendments be made to the remainder of the Constitution:

(1) Substitute the words "Board of Trustees" in lieu of the word "Council" wherever said word appears therein. (2) Substitute the word "Trustees" in lieu of the word "Councilors" wherever said word appears therein. (3) Substitute the word "Trustee" in lieu of the word "Councilor" wherever said word appears therein.

This has the effect of renaming the present Council as the Board of Trustees to place it in conformity with the organizational structure of the AMA and other state associations and makes it definite that the trustee is a trustee and not a member of an appointed council or commission of the association.

GORDON S. FESSLER, M.D.,

Chairman

GEORGE W. WILLISON, M.D.

HARRY B. PARMENTER, Jr., M.D.

THOMAS H. GOOTEE, M.D.

M. C. TOPPING, M.D.

JAMES F. LEWIS, M.D.

JOSEPH F. FERRARA, M.D.

B. D. WAGONER, M.D.

CHESTER L. WAITS, M.D.

O. L. MARKS, M.D.

RICHARD L. GLENDENING, M.D.

MAURICE E. GLOCK, M.D.

EDWIN C. MUELLER, M.D.

WILLIAM M. SHOLTY, M.D.

BURTON KINTNER, M.D.

Legislation

The legislative commission had its organizational meeting on October 30, 1966 and discussed mandates and suggestions from the Indiana State Medical Association House of Delegates. These included:

1. Points to be considered in any bill proposed to implement Title XIX of the Medicare Law.
2. Support of legislation designed to implement the "Indiana Plan" for statewide medical education but not to take any position on location of any proposed second medical school.
3. Investigation of how the Medical Licensure Act could be administered to allow interns and qualified M.D.'s to more easily secure Indiana licenses.
4. Support mandatory tuberculin testing of children starting to school.
5. Eradication of open dumps and encouragement of the use of sanitary land fills.
6. Inspection of all meat and poultry in Indiana.
7. Support of State Board of Health in its proposal of state subsidies for local health departments.
8. Development of the Forensic Science Commission as a means of promoting the medical examiner system for Indiana.

The next meeting was held following the Inter-Professional Health Council meeting on December 14, 1966, where legislative matters of mutual concern were discussed. Our commission then made plans for the impending legislative session.

Starting on Wednesday, January 11, 1967, seven weekly meetings of the full commission were held. As per custom, all bills which were introduced in the legislature and appeared to have medical significance were reviewed. Decisions were made as to our position on the bills and subsequently this information was disseminated through channels to the various ISMA components. At these weekly meetings several doctors appeared to voice their opinions on different legislative items. Beginning early in January, our legal advisors, Mr. Hollowell and Mr. Robinson, were at work drawing up bills for which the commission had been mandated to seek legis-

lative action. On February 1, 1967 the commission hosted the members of the Senate and House Public Health Committees at a luncheon meeting.

We were afforded excellent cooperation and support by the State Board of Health and Dr. Offutt and/or Dr. Yoho generally attended our meetings. Dean Irwin of the medical school also gave generously of his time to meet with us relative to medical education legislation.

As always, the bulk of the day-to-day legislative work load fell on our two field men, Robert Amick and Howard Grindstaff, with timely and appropriate assistance from Jim Waggener and Robert Robinson. As president of the Indiana State Medical Association, Dr. Rifner was a faithful attendee of the meetings and gave testimony to appropriate legislative committees. Other officers and ISMA members in addition to the commission members gave heavily of their time in contacting individual legislators and giving formal testimony when asked. All-in-all, it was a rather grueling legislative session because of several factors, but mainly due to the divided political complexion of the two houses.

We might sum up the results by saying that organized medicine was not hurt and some gains were made. Considerable commission effort was lost when the governor vetoed the bill implementing Title XIX of the Medicare Law. Mixed opinions still are present about Title XIX, but it will be back in 1969 for consideration. Probably the biggest disappointment to the commission was the failure to get the forensic science or medical examiner bill passed. Tremendous time and effort were expended only to see it held up in the Senate and dramatically fail to be called up for final passage. It, too, will return in 1969. The Indiana Plan for Statewide Intern-Residency Program was passed after considerable maneuvering and compromising.

A certification bill for psychologists, which evolved after much time and effort by Indiana psychologists and members of the Section on Nervous and Mental Diseases of the Indiana State Medical Association, passed both houses but was vetoed by the governor. A bill liberalizing Indiana's 1904 Abortion Law met the same fate. Your commission had advised on the medical aspects of the proposed bill. A bill regulating hearing aid sales and one to require testing for tuberculosis of children entering school did become laws. Numerous bills considered to be harmful for the public health in general were blocked. Only those who have participated in these 61-day legislative sessions can fully appreciate the time required, the headaches, frustrations and the satisfactions involved; again, the commission gives grateful thanks

to the full-time Indiana State Medical Association staff men who keep ISMA effective and well accepted by the lawmakers and government officials.

Even though legislative matters on the state level took the forefront this year, national medical legislative issues were not neglected. The annual reception for the Indiana delegation in Congress and the chief administrative assistants was held April 11, 1967 in Washington, D. C. In addition to members of the Indiana State Medical Association Executive Committee, your legislative chairman and vice-chairman attended. This meeting, which always affords opportunity for strengthening communication with our Washington legislators, was an exceptionally successful one.

The chairman of the commission takes this opportunity to thank the members of the commission, the officers and staff of Indiana State Medical Association for the support given during this year. Last but not least, the Auxiliary to Indiana State Medical Association is recognized for the time and effort expended by its officers and legislative committee in helping to promote the program and functions of this commission.

DWIGHT W. SCHUSTER, M.D.
Chairman

EUGENE F. SENSENY, M.D.,
Vice-Chairman

JACK W. HICKMAN, M.D.,
Secretary

DANIEL M. HARE, M.D.

HAROLD MANIFOLD, M.D.

ELMER L. WALLACE, M.D.

LESLIE M. BAKER, M.D.

FRED W. DIERDORF, M.D.

JOHN DAVIS, M.D.

GUY A. OWSLEY, M.D.

MAX N. HOFFMAN, M.D.

DANIEL RAMKER, M.D.

LESTER RENBARGER, M.D.

OTIS R. BOWEN, M.D.

DON E. WOOD, M.D.

JOE BLACK, M.D.

JAMES M. KIRTLEY, M.D.

Public Health

This commission was formed with 24 members and consultants, October 30, 1966. The commission was divided into the following committees: Industrial Medical Practices and Programs; Preventive Medicine and Liaison with State Board of Health; Rural Health and Physician Placement; Traffic Safety; School Health; Environmental Health, with Doctors Lamb and Offutt as general consultants. Initially, this commission considered various items of public health legislation referred to it by the Legislative Commission and other groups and submitted reports to the appropriate ISMA commission or committee.

Considerable opposition was presented to compulsory vaccination laws, but there was a majority support for the VD and LSD control laws. This commission feels that it would be wise if all proposed public health laws and regulations were brought to its attention as soon as possible so that an opinion can be formulated to assist the Legislative Commission as it carries on its function. It was also felt that this should not be a function just for pre-legislative weeks but should parallel the discussions and preparations for legislative action by the various commissions of the state legislature during the interim between sessions. Members of this commission of the ISMA would be agreeable to rendering an opinion to various state legislature commissions in regards to matters coming under its purview.

The Committee on Industrial Medical Practices and Programs encountered no particular problems during the year. Disposition of prior publications has continued. It was anticipated that participation by committee members in conferences will bring new and different insights into some of the problems in this area of medicine.

Considerable activity was accomplished in the field of preventive medicine. Early in the year a program proposed by the Indiana Association for Retarded Children was modified in a conference with members of the commission and a fairly successful effort at promoting community-wide programs for measles immunizations has resulted. The commission can take but little credit for the amazing drop in incidence of rubeola. It has contributed collectively and through the efforts of individual members in promoting the "Eradicate Measles" program of the Indiana State Board of Health. These programs are currently operated within the framework of the existing type of practice of a community and are directed to those individuals who would not ordinarily receive immunizations from their private physician.

A new and more positive attempt at control of tuberculosis enacted by the last legislature will ensure a more thorough screening of children at an early pre-school age. In those areas where kindergartens are a formal part of the school system, this testing will be done on four or five year old children. There are certain phases of this law and its accompanying regulation which perhaps need modification, but the overall effect should be one of earlier case finding. Venereal disease continues to be a problem with reported cases of syphilis exceeding that of 1966 and gonorrhea showing essentially the same case rate. Reports still indicate that the incidence of new cases is highest during late adolescence, and this matter shall receive continuing

concern of the commission and cooperation with State Board of Health programs in any way possible. The chairman of the commission represented the state medical association in the planning and development of the program for control of infectious disease within hospitals. This program is to be presented under the auspices of the participating groups and the communicable disease center and other agencies of the Department of Health, Education and Welfare in September.

The Committee on Rural Health and Physician Placement again conducted the annual Junior-Senior Day program. As previously reported, this was again a successful program with attendance exceeding 150. The program was well received. It had been the impression of commission members that this program was largely duplicating the effort of the Indiana Academy of General Practice and that it really was not bringing to the attention of students the varied opportunities for practice within the state of Indiana. These impressions were fully substantiated by the results of a questionnaire prepared during the conference by those students in attendance. Accordingly, the emphasis of Junior-Senior Day for 1968, with the concurrence of the Council of the Indiana State Medical Association, will be to retain physicians of all categories for practice in the communities of this state. While the results of this questionnaire cannot be statistically validated, the replies indicate that many students are motivated to seek a place for further medical training and for eventual practice on the basis of the recreational possibilities of the area, the immediate monetary advantages and the desire to see a bit more of the world than a lifetime of schooling in Indiana has afforded them. While many of these aims are valid, it would appear that much of their motivation is, at least for these 48 respondents, not in accordance with the ideals of attaining a professional competence or providing service where needed.

Traffic safety has again occupied considerable effort of the commission in cooperation with the Indiana State Police and the universities of the state. Of particular interest is the recently enacted Motorcycle Safety Law which should decrease the usually tragic consequence of incidents involving such vehicles. Other aspects of traffic safety involving cooperation with the police training departments of Indiana University are continuing.

In the field of school health, the committee has been active in the development of physical standards for athletes, participation in the annual sessions for school bus drivers including preparation of a bus driver manual by some members of the

commission acting at the request of the Indiana Health Services Foundation. Members of the commission have also been active in the annual school health programs participating both in the planning stage and the programs. Much remains to be done. It is hoped that a school health conference involving physicians and educators can be developed within the near future. In this same context, the idea of a Health Fair has been considered by the commission. Whether or not this should be a part of the state medical convention or a separate event has not been decided, but it is our recommendation to the Council that this not be a part of the convention. There are other activities being planned which would make it much more feasible to plan an effective Health Fair; especially that planned by the Indiana Inter-Agency Council on Smoking and Health. This organization, recently established, carries representation from and support of the Indiana State Medical Association. Its aims are primarily that of coordination in developing programs for member agencies to present. The main effort of this group is currently directed to the development of an in-service training program for elementary teachers. Also in the planning stage is a program whereby junior high school students, representative of their schools, will be brought for a conference promoting abstinence from smoking by persons prominent in sports, beauty contests, science and other activities of interest to adolescents. It might be wise to develop the concept of a Health Fair in conjunction with this program.

The Committee on Environmental Health of the commission has been active in two fields. It has participated in the establishment of water quality control standards for various water sheds and basins in the state. On June 29, the commission met at Lake Monroe and, with a fairly good number in attendance, toured the lake, inspected the water filtration plan which will serve Bloomington and Monroe County as well as the water filtration and sewage disposal systems at the Ransberg Ranch Boy Scout Reservation. The various types of waste disposal and environmental health programs currently in use or being developed at the new recreational centers such as this were discussed by experts from the State Board of Health, the local county health departments and the management of the reservoir. It was pointed out that much of what these people offered is applicable to pending development in the northern Wabash Valley and to rehabilitation of older recreational facilities. The role of the physician, singly and collectively, in the development and maintenance of these recreational areas was shown to be extremely important, and

often lacking.

Further efforts of the commission will be to cooperate with those governmental and private agencies which will further the public awareness of the need for continuing and improved environmental sanitation and preventive medicine in recreational areas especially.

It is not anticipated that the commission will initiate any specific projects other than those relative to their function within the society; however, it is evident that much more effort will need to be placed on traffic safety and venereal disease control. It is also requested that the state medical association take cognizance of its responsibility to coordinate and encourage public health efforts in those areas under state control and/or involving multiple local governing units.

T. O. MIDDLETON, M.D., *Chairman*

T. NEAL PETRY, M.D.,

Vice-Chairman

BERNIECE M. WILLIAMS, M.D.,

Secretary

ARNOLD W. BROCKMOLE, M.D.

GLEN D. LEY, M.D.

ROBERT SEIBEL, M.D.

CLEON M. SCHAUWECKER, M.D.

W. L. DALTON, M.D.

HENRY G. NESTER, M.D.

STANLEY W. BURWELL, M.D.

THEODORE C. PERSON, M.D.

GILBERT Z. GIVEN, M.D.

JOHN E. SCHREINER, M.D.

THEODORE J. SMITH, M.D.

BERTRAM S. ROTH, M.D.

HARRY S. FEINN, M.D.

Ex-Officio

ROBERT YOHO, Ph.D.,

Consultant

LOUIS W. SPOLYAR, M.D.,

Consultant

EMERSON C. HARVEY, Jr., M.D.,

Consultant

ALBERT L. MARSHALL, Jr., M.D.,

Consultant

RICHARD L. SCHULTHEIS, M.D.,

Consultant

JOHN A. DAVIS, M.D.,

Consultant

ANDREW C. OFFUTT, M.D.,

General Consultant

EMMETT B. LAMB, M.D.,

General Consultant

Voluntary Health

The commission is made up of the following:

(1st Distr.) Albert S. Ritz, 3700 Bellemeade Ave., Evansville

(2nd Distr.) Ed R. Cantwell, 202 Broadway St., Vincennes

(3rd Distr.) vacancy

(4th Distr.) Harry R. Baxter, 326 N. Walnut St., Seymour

(5th Distr.) William G. Bannon, 416 Rose Dispensary Bldg., Terre Haute

(6th Distr.) Wayne H. Endicott, 10 W. Boyd St., Greenfield

(7th Distr.) William A. Karsell, 3989 Meadows Dr., Indianapolis

(8th Distr.) James S. Fitzpatrick, 603 W. Arch St., Portland

(9th Distr.) Albert E. Applegate, 1303 S. Jackson St., Frankfort

(10th Distr.) John G. Kolettis, 6111 Harrison St., Gary

(11th Distr.) Wendell W. Ayres, 500 Wabash Ave., Marion

(12th Distr.) Richard Willard, R. #4, Bluffton

(13th Distr.) William F. Oren, 919 E. Jefferson Blvd., South Bend

(At Large) James H. Gosman, 1815 N. Capitol Ave., Indianapolis

(At Large) Norman R. Booher, 447 E. 38th St., Indianapolis

This commission has continued to be active along the lines established in previous years.

The organizational meeting was held on October 30, 1966, and Dr. Wendell Ayres was elected secretary; Dr. James Gosman, vice-chairman and Dr. Norman Booher, chairman.

The members of the commission were all assigned specific voluntary health agencies having a statewide program in Indiana as their responsibility. This responsibility included close liaison with these agencies throughout the year, becoming acquainted with the officers and staff of each agency and, in most instances, our representatives received the official minutes of the policy making bodies of the agencies and in some instances sat in with this policy making body. In addition, each member of the commission reviewed the annual report of the agency and recommended appropriate action on the part of the commission so far as recognition is concerned.

One of the greatest concerns of this commission is communication between the physicians of the Indiana State Medical Association and the voluntary health agencies.

In addition, the commission has felt for many years that there should be some way of disseminating information gleaned by this commission in its many hours of work and that it should be passed on to the general public, giving credit where due for the fine work most of the voluntary health agencies do in their field and which merits support by the general public. It is also felt it was important that the physicians understand the work of these agencies so that they can understand the valuable contributions made by the agencies.

The health agencies recognize that without the support of organized medicine, their

work is difficult, if not impossible. The commission feels that every effort should be made by the doctors of this association to give sound medical guidance to these agencies which are working in the health field.

On December 7, 1966, a joint meeting was held between representatives of the voluntary health agencies on the recognized list and members of the commission, to plan a scientific program to be sponsored jointly by the voluntary health agencies and the Commission on Voluntary Health Agencies of the Indiana State Medical Association. A program was formulated to be of wide general interest both to the medical profession and laity interested in health agency work.

A meeting of the commission was held on January 29, at which the technical business of the commission was discussed during the first part of the meeting. One of the problems presented at this meeting concerned the fact that some voluntary health agencies which work on a local basis have asked for recognition by the ISMA. The policy was established two years ago that this commission of the state medical association could only deal with agencies having a statewide program. It was felt that county medical societies should formulate similar committees to deal with the programs of those agencies that operate strictly on a county or regional basis. Because of this policy, a few agencies who set forth on their letterheads that they were endorsed by this commission have been contacted and in each instance have agreed to delete this endorsement from their letterhead.

At this meeting, further discussion of the publication of a placard to be sent to each member of the Indiana State Medical Association for display in his office took place. The commission had referred the legal question of the publication to the attorneys of the association and received back a detailed letter, dated January 11, from Hollowell and Robinson, which was a legal opinion on this matter, signed by Mr. Robert Hollowell. Based on this opinion, the commission voted to prepare and distribute such a placard, giving the names of those voluntary health agencies with statewide programs that had met the criteria established by this commission for recognition by the Indiana State Medical Association.

This placard was prepared in rough draft and submitted to the attorneys for further opinion and was printed exactly as the attorney advised. Subsequently, a copy of this placard was mailed to each member of the ISMA with a covering letter requesting that it be displayed in his office. Since that time, a great deal of very favorable

comment has been received from physicians and especially from the voluntary agencies listed thereon. This placard has received considerable national attention and all in a favorable light. This commission feels that this placard, which will be reprinted annually, is the most concrete work that it has been able to complete. We find that the existence of such a placard has made the voluntary agencies even more anxious to conform to the criteria set forth. Incidentally, the criteria under which we work is a part of the distributed placard.

In the second half of the meeting, members of the commission met with representatives of all the voluntary agencies, including the president and the executive officer of these agencies.

Final plans were made for the scientific meeting to be held as a part of the annual meeting of the Public Health Association on April 26, 1967. A great deal of discussion between the agency representatives and the commission followed and the general tenor of this discussion was most favorable to the public relations impact of our work with the volunteer groups. The one thing that was brought out most often by the agency groups was the emphasis on the need for participation by reputable physicians in the affairs of these agencies. They continue to plead for the participation of physicians, not only in the execution of their programs but in the policy making of their organizations. Many of the agencies felt that there should be a committee on voluntary health agencies in each county medical society which their local affiliates could consult for guidance.

The final effort of the commission was the joint scientific meeting entitled, "The Second Annual Medicine and Voluntary Health Day", held on April 26, 1967, as an integral part of the annual meeting program of the Indiana Public Health Association. The cooperation of Dr. Charles Rushmore, program chairman, and Mr. Sam Elder, president of the Indiana Public Health Association, was greatly appreciated.

In cooperation with the American Cancer Society, Dr. Leonard W. Larson, past-president of the American Medical Association, talked on "Medical Education in the Future." Dr. Larson spoke as a member of the Millis Commission on this subject.

Mr. John Mote, assistant executive director of Methodist Hospital, Indianapolis, presented a challenging address on, "Changing Personnel in Health Care" and Dr. George Lukemeyer, associate dean of Indiana University School of Medicine, elaborated on the "Use of the Computer System in the Indiana Plan of Postgraduate Education" and the use of the computer in the clinical practice of medicine in the

state of Indiana, and finally, through the sponsorship of the Marion County Hospital Development Corporation, Dr. Richard Yoder, of the University of California, spoke on, "The Computer System in Medicine." Dr. Yoder gave a most challenging address which stimulated everyone who heard him.

There was good attendance at this meeting by laity, although the number of physicians present left much to be desired. This meeting had been preceded by breakfast, which was given by the ISMA for the officers of the voluntary health agencies and the speakers. The members of the commission convened for a regular meeting after the scientific meeting and held a final meeting of their commission that afternoon.

It was noted at the final meeting that a vacancy has existed from the Third District and no replacement has been made. It was further noted that certain members of this commission have failed to attend any meeting of the commission during the entire year, but that those who have attended have been very faithful to their duty and have again completed a large amount of work in the interest of the Indiana State Medical Association.

At this final meeting the questionnaires of several agencies were reviewed. Some were recognized and others were asked to make further explanation of their programs.

As a result of the labors of this commission, the following voluntary health agencies, having statewide programs, have been recognized for the current year by the Indiana State Medical Association as meeting our criteria and worthy of the support of organized medicine and the public in general:

American Cancer Society, Indiana

Division

The Arthritis Foundation

Indiana Society for Prevention of

Blindness

Indiana Society for Crippled Children
& Adults, Inc.

Tri-State Epilepsy Society, Inc.

Indiana Heart Association, Inc.

Indiana Association for Mental Health

Indiana Chapter, National Multiple

Sclerosis Society

Myasthenia Gravis Foundation, Inc.

Indiana Association for Retarded
Children, Inc.

Indiana Tuberculosis Association

United Cerebral Palsy of Indiana, Inc.

The chairman of this commission desires to thank all the members of the commission who have performed faithful service. It has been a busy and pleasant year and the efforts on the part of the headquarters staff have been most helpful. Under the

direction of Mr. James Waggener, Mr. Kenneth Bush has been very active in the work of the commission and his contact with other organizations has proved particularly valuable. The faithful service of Miss Eleanor Chapple as secretary of the commission is again commended and much appreciated.

NORMAN R. BOOHER, M.D., *Chairman*

Medical Economics and Insurance

The commission met on three occasions: October 30, 1966, and January 22 and April 22, 1967, and the following matters were considered:

1. *Disability Insurance Program* — the commission feels that a sound program has been presented and urges that it be given full opportunity to develop. The Council was informed that the commission does not favor a deadline for termination of the program as recommended by the Reference Committee on Insurance at the ISMA meeting in October, 1966. A recent communication from the administrator of the program notes: "that the plan is completely sound from an underwriting standpoint, claims have been incurred and paid and that a substantial number of your eligible members are insured and enjoying this additional service of the association." Almost 400 applications have been received and nearly 300 are insured. In addition, the insurance company has recently agreed to offer insurance to every applicant, including those who are not medically or otherwise acceptable for the regular plan in another division of the Continental Casualty Company.

We need more doctors enrolled and feel that our broker must make more vigorous his promulgation of the program.

2. The Executive Secretary of the association was instructed to notify the St. Paul Mercury Indemnity Company that the House of Delegates had rescinded approval of this company as official carrier of malpractice insurance for the association.

3. *Retirement Program* — two of our meetings were largely devoted to consideration of an association-approved retirement program. Mr. Samuel Rea of Lubin Associates presented the plan adopted by the Indiana State Bar Association and Fort Wayne Medical Society to the commission, and the pension plan developed for the Lake County Medical Society by Prudential Insurance Company was discussed. A plan proposed by National Services, Inc. of Columbus, Ohio, utilizing Blue Shield fees was considered to be unacceptable to Blue Shield and to the ISMA.

Mr. Robert Milroy of the Indiana Uni-

versity School of Business was invited to speak to the commission on April 22 as a disinterested expert in the field of pensions and retirement. His discussion of the ramifications, types, advantages and disadvantages of various programs educated all of us, and he will probably be consulted again. At this time, the commission is not ready to recommend a plan to the association and is not sure that it should, in view of other plans available through county medical and specialty societies and the AMA. The retirement program of the AMA has been considerably enhanced by the 1966 amendment of the Keogh law.

4. County society insurance review committees were under discussion, and the commission unofficially reiterated its approval of such committees.

5. The trials of the AMA disability insurance program were discussed — most commission members unofficially favored a new vendor with retention of the same benefit and premium levels.

The chairman is most appreciative of the time and effort dedicated to these endeavors by the other members of this commission.

CHESTER A. STAYTON, JR., M.D.

Chairman

THOMAS G. HAMILTON, M.D.

Vice-Chairman

W. R. VAN DEN BOSCH, M.D.

Secretary

EDWARD J. PLOETNER, M.D.

WILLIAM A. JOHNSON, M.D.

THOMAS J. CONWAY, M.D.

JOHN LING, M.D.

CHARLES M. SINN, M.D.

JAMES M. LEFFEL, M.D.

CHARLES E. GECKLER, M.D.

PAUL W. HOLTZMAN, M.D.

R. JAMES BILLS, M.D.

RICHARD WAGNER, M.D.

JACK W. HANNAH, M.D.

WILLIAM J. MILLER, M.D.

Inter-Professional Relations

During the past year the commission considered two main projects, the first being continued exploration and scheduling of a meeting to establish an Indiana Association of the Professions. During this time many of the professional groups were contacted and the majority expressed enthusiastic desire to enter into the formation of such an association. The commission will continue to work toward this end.

A second project was to form a liaison sub-committee with representatives of the Indiana State Nurses Association for the purpose of discussing problems of joint concern and making recommendations to improve nursing service, generally. Three meetings were held during the year. At

the first informal discussion of present day nursing education; interpretations of hospital administrations and physicians of specific responsibility of nurses; the extent of nursing service in hospitals; the variety of duties expected of them and the expectations of patients concerning nurses care was made.

In subsequent meetings several problems pertaining to the nurses function and nursing service in general were discussed. These included the recruitment of nurses; the relationship of hospital's administration to nursing service; the erosion of head nurses authority by medical care specialists, e.g., physiotherapists, inhalation therapists, etc.; creditation on nursing service; establishment of standards and qualifications for hospital nursing service; the problem of the developing fearful attitude among nurses in training toward general nursing duty with a result that many enter nursing specialties; and the problem of thrusting inexperienced and newly-trained nurses into positions of responsibility for the care of large numbers of patients. It is generally agreed that nurses presently feel that they need more clinical instruction with relatively less time in the classroom before graduation.

Tentatively, the recommendations are that every physician and nurse be made aware of the need for cooperating, especially with the physician fulfilling his responsibility to take time to instruct the nurse; that a student nurse should not be used in physicians' performance of major responsibility and that it may be well to establish a "Mandatory Nursing Practice Act", that nursing services should be accredited.

The next meeting of the liaison committee will be held on Sunday, September 17, 1967 with a full membership of the commission and representatives of the Indiana Nurses Association to be invited.

At this meeting it is expected that resolutions will be formulated which will be submitted to the Indiana State Medical Association House of Delegates and Indiana Nurses Association delegates body for their consideration.

PIERRE C. TALBERT, M.D.,

Chairman

FRED FLORA, M.D.,

Vice-Chairman

VIRGIL E. ANGEL, M.D.,

Secretary

A. WAYNE RATCLIFFE, M.D.

ROBERT H. RANG, M.D.

CHARLES X. McCALLA, M.D.

JOHN W. RIPLEY, M.D.

PAUL HUMPHREY, M.D.

WILLIAM S. ROBERTSON, M.D.

WILLIS W. STOGSDILL, M.D.

ROBERT D. WILLIAMS, M.D.
H. H. DUNHAM, M.D.
ROBERT H. DENHAM, Jr., M.D.
A. ALAN FISCHER, M.D.
ROBERT G. HUSTED, M.D.

Medical Education and Licensure

The main effort of the commission this year has been the continued implementation of the Preceptorship Program. Drs. Kenneth Sherer and George Lukemeyer have been in charge of this work.

At the meeting of the commission in May there was discussion on the subject of encouraging and widening the internship and residency programs in the year ahead. If some success can be achieved here, it is felt that Indiana will be more successful in retaining more of the graduates from the state as practitioners here. Based on population, Indiana trains a disproportionately large number of doctors, and of these, too large a percentage go to other states to practice.

Another good meeting of the Commission on Medical Education and Licensure was held with the State Board of Medical Registration and Licensure. Serious discussion was held on the subjects of:

(1) The great increase in the past three years of foreign graduates taking the board examinations.

(2) The incorporation into licensing laws of clauses regarding competence and psychiatric health, and suggestions on minimal requirements for continuing postgraduate education.

The commission is cooperating with the Indiana University Medical Center in a major postgraduate education program, and is actively interested in cooperating in the nationwide grand rounds program.

The chairman wishes to thank the members of the commission for the long hours and dedicated service which they have given this year.

JAMES B. JOHNSON, M.D.,
Chairman

JOHN L. CULLISON, M.D.,
Vice-Chairman

FORREST R. LaFOLLETTE, M.D.,
Secretary

JOHN STERNE, M.D.

WALTER VAUGHN, M.D.

JOHN M. PARIS, M.D.

RICHARD A. SNAPP, M.D.

KENNETH E. SHERER, M.D.

GEORGE T. LUKEMEYER, M.D.

PETER R. PETRICH, M.D.

LEO RADIGAN, M.D.

LOWELL J. HILLIS, M.D.

JOEL SALON, M.D.

JENE R. BENNETT, M.D.

MERRITT O. ALCORN, M.D.

GLEN W. IRWIN, Jr., M.D.,
Ex-Officio

Special Activities

The Commission on Special Activities met three times during the year. The commission was concerned with two major projects: (1) Better orientation of new ISMA members and; (2) Blood banks. It was felt by the members of this commission that better orientation of new ISMA members could be aided by the following:

1. A combined dinner and orientation course to be held in Indianapolis, preferably approximately one month after the state meeting in October. It would be a one day meeting starting early in the afternoon and culminating in a dinner in the evening. All new ISMA members would be required to attend one of their first two years in practice. The expense of the meeting would be the responsibility of the Indiana State Medical Association. Such speakers as the ex-president of Indiana State Medical Association, Dr. Don Wood, and other experienced members would be encouraged to help indoctrinate the new members.

2. The councilor of each district would hold an informative course pertaining more to the policies of districts and county societies, preceding each annual district meeting. The training course should last approximately two hours with all new district members being required to attend one of their first two years in practice.

3. The ISMA offices should continue to issue literature as recommended below:

1. A copy of the Indiana Medical Practice Act.

2. *The American Medical Association*. A booklet describing activities of the AMA.

3. *Social Security for Physicians*. U. S. Department of Health, Education and Welfare.

4. A booklet, if available, of *Mental Health Resources in Indiana*.

5. *Constitution and Bylaws of the Indiana State Medical Association*.

6. *Professional Liability and the Physician*. A report on the Committee on Medico-Legal Problems — American Medical Association.

7. A report, if available, from the Postgraduate or Continuing Education Division of the Indiana University School of Medicine.

8. Organization and function of departments of Indiana government.

9. Roster of the Indiana State Medical Association.

10. *The Business Side of Medical Practice*. A booklet published by the American Medical Association in cooperation with the Sears-Roebuck Foundation.

11. An explanation of Board of Health

rules and regulations dealing with medicine and hospitals.

12. A letter from the president of ISMA.
13. An explanation of AMA and ISMA Retirement and Disability Insurance Programs.

14. Six publications on medicine:

1. *Medical Insurance Claims Under Medicare — Methods of Payment*.

2. *Your First \$50. of Medical Insurance Expenses*.

3. *Medicare and the Extended Care Facility*.

4. *How Much Does Medicare Pay for Outpatient Hospital Services*.

5. *How Medicare Helps to Pay a Home Health Agency for Providing Your Home Health Benefits*.

6. *When You Enter a Hospital — How Does Medicare Help*.

15. A statement of availability of legal counsel from Indiana State Medical Association.

16. *Judicial Council Opinions and Reports — AMA*.

17. A copy of reprint entitled, *The Etiquette of Referrals* — Vol. 61, February, 1965 *Texas State Journal of Medicine*.

18. *Physicians Handbook on Death and Birth Registration*. U. S. Department of Health, Education and Welfare.

19. Indiana Vital Statistics Law and Regulations (if available).

20. Indiana Narcotic, Barbiturate and Amphetamine Drug Laws and Regulations (if available).

21. *Winning Ways with Patients*. A public relations aid for the physicians' medical assistants.

22. *Health Insurance for the Aged — Hospital Manual*.

23. *Do's and Don'ts for the Medical Witness*. Law Department, AMA.

24. *For Physicians — Reference Guide to Health Insurance Under Social Security*. U. S. Department of Health, Education and Welfare.

25. Calendar of annual state medical meetings.

It is hoped the Council and Executive Committee approves funds and formulated plans for such an indoctrination program.

Blood banks in Indiana occupied much of the committee's time. Surprisingly little information on blood banks in Indiana was available. Thus the Special Activities Committee, with the help of the Indiana State Medical Association headquarters staff, compiled the first and only listing of blood banks in Indiana. A copy of this list is printed below.

We further studied the major blood banks; their methods of securing blood, quality control, costs of operation, super-

visory personnel and problems in general associated with blood banks, what is done with outdated blood and future plans for blood banks. Help with the above considerations was supplied during a meeting with Mr. John Keilholz, Director, Community Blood Bank of Marion County, Inc.; Dr. Victor Muller, Medical Director, Community Blood Bank of Marion County, Inc.; Mr. Neil Robson, Director, Red Cross of Fort Wayne and Miss Evelyn Fleming, Administrative Director, Louisville, Kentucky Blood Bank. Although these authorities supplied much information, nevertheless we still lack information on the smaller blood banks of Indiana.

A questionnaire is now being sent to all hospitals by Mr. Kenneth Bush, re-

questing help in answering some presently unanswered questions as:

- a. What disposition is made of outdated blood?
- b. What procedure is followed in procuring donors?
- c. What are the problems in procuring blood?
- d. What are the charges incurred to the hospital and to the patient?

Until the results of these questionnaires are tabulated, final recommendations by this committee to the Council and Executive Committee of the Indiana State Medical Association cannot be made.

Several proposals are being offered to:

- 1. Determine the best source of blood.
- 2. Determine the best possible quality control and handling at the least price.

- 3. Encourage fractionation of near outdated blood to prevent unnecessary blood waste.
- 4. Encourage all Indiana State Medical Association members to become more familiar with their supplying blood bank, its method of operation and how it compares with other blood banks.
- 5. Encourage all blood banks to have an interested physician in charge.
- 6. Discourage federal government control of Indiana blood banks.
- 7. Encourage the setting up of a display concerning blood banks at the next state medical meeting, if possible.
- 8. Encourage a lecture series at a future state meeting on blood banks and their operation.

Supplementary Report

HOSPITALS AND BLOOD SUPPLY SOURCES

City	Hospital	Supply Source
Jeffersonville	Clark County Memorial	American Red Cross Blood Center, Louisville, Kentucky. Private donors when necessary. Voluntary donors. Clubs and local factories.
Jasper	Memorial Hospital	Orange County patients receive blood from Louisville American Red Cross Blood Center, on exchange basis.
Paoli	Orange County Memorial Hospital	American Red Cross Blood Center, Louisville.
Crown Point	James O. Parramore Hospital	Methodist Hospital, Gary.
Salem	Washington County Memorial Hospital	American Red Cross Blood Center, Louisville.
Madison	King's Daughters' Hospital	American Red Cross Blood Center, Louisville. Local donors if emergency or other reasons.
Vincennes	Hillcrest Tuberculosis Hospital	Good Samaritan Hospital.
Indianapolis	University Heights Hospital	Other hospitals.
Batesville	Margaret Mary Hospital	Blood Bank Foundation, Nashville, Tennessee. American Red Cross Blood Center, Louisville. Blood donors.
New Albany	Southern Indiana Tuberculosis Hospital	American Red Cross Blood Center, Louisville.
Washington	Daviess County Hospital	Regional blood center. Local donors.
Evansville	Welborn Memorial	Commercial Blood Bank, St. Louis. Evansville, Nashville, Louisville Red Cross. Relatives and friends of patients; professional donors; professional commercial banks; 75%; Red Cross Blood Bank, 25%.
Williamsport	Community Hospital	Walking blood bank.
Tell City	Perry County Memorial Hospital	Perry County Walking Blood Bank.

<i>City</i>	<i>Hospital</i>	<i>Supply Source</i>
Corydon	Harrison County Hospital	Red Cross Blood Center, Louisville.
Indianapolis	St. Elizabeth's Maternity Hospital	Red Cross Blood Center, Louisville.
Anderson	St. John's Hickey Memorial Hospital	Volunteer donors. Paid donors. Blood exchange thru: Marion County; Commercial Blood Bank; American Associated Blood Banks; Red Cross.
Greensburg	Decatur County Memorial Hospital	Donors. Community Blood Bank.
Franklin	Indiana Masonic Home Hospital	Community Blood Bank of Marion County via Johnson County Memorial Hospital.
New Albany	Memorial Hospital of Floyd County	Red Cross Blood Center, Louisville. Rarely draw our own donors.
Evansville	Boehne Tuberculosis Hospital	Other hospitals.
Rockville	Indiana State Hospital for Chest Diseases	University Hospital. St. Anthony's Hospital, Terre Haute.
Brook	George Ade Memorial Hospital	Donation — volunteer.
Lawrenceburg	Dearborn County Hospital	Red Cross Blood Center, Louisville.
Seymour	Jackson County Schneck Memorial Hospital	Red Cross Blood Center, Louisville.
Rensselaer	Jasper County Hospital	Local donors 98%. Community Blood Bank.
Anderson	Community Hospital of Madison County	Own donors. Community Blood Bank of Marion County, Indianapolis.
Sullivan	Mary Sherman Hospital	Volunteer donors. Professional donors (few).
Hammond	St. Margaret Hospital	Own blood bank.
East Chicago	St. Catherine Hospital	Own blood bank.
Monticello	White County Memorial	Red Cross — Fort Wayne.
Crawfordsville	Montgomery County Culver Union Hospital	Professional donors. Friends of patients.
Bloomington	Bloomington Hospital	Red Cross Blood Center, Louisville. 5-10% own drawing.

ROSTER OF BLOOD BANKS AND DRAWING STATIONS

<i>City</i>	<i>Blood Bank and Address</i>	<i>Comments</i>
Beech Grove	St. Francis Hospital Blood Bank, N. 17th Ave. (46107)	
Brazil	Clay County Hospital Blood Bank, 1206 E. National Ave. (47834)	Affiliate of Union Hospital BB, Terre Haute.
Clinton	Vermillion County Hospital Blood Bank, 801 S. Main St. (47842)	Affiliate of Union Hospital BB, Terre Haute.
Connersville	Fayette Memorial Hospital Blood Bank, 1941 Virginia Ave. (47331)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Danville	Hendricks County Hospital Blood Bank, 1000 E. Main St. (46122)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Elkhart	Elkhart General Hospital Blood Bank, 600 East Boulevard (46514)	

<i>City</i>	<i>Blood Bank and Address</i>	<i>Comments</i>
Evansville	Protestant Deaconess Hosp. Blood Bank, 600 Mary St. (47710)	
Franklin	St. Mary's Hospital Blood Bank, 1700 Washington Ave. (47715) Johnson County Memorial Hospital Blood Bank (46131)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Gary	Methodist Hospital of Gary Blood Bank, 1600 W. Sixth Ave. (46402) St. Mary Mercy Hospital Blood Bank, 548 Tyler St. (46402) Scientific Blood Bank, 1620 Broadway (46407)	Drawing station of Scientific Blood Bank, Inc., Chicago, Illinois, (trial participant). Affiliate of Union Hospital BB, Terre Haute.
Greencastle	Greencastle Blood Bank, Putnam County Hospital, 330 Greenwood Ave. (46135)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Greenfield	Hancock County Memorial Hospital Blood Bank, 800 N. State St. (46140)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Greensburg	Decatur County Memorial Hospital Blood Bank, 720 N. Lincoln (47240)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Hartford City	Blackford Clinical Laboratory Blood Bank, Blackford County Hospital, 503 E. Van Cleve St. (47348)	Affiliate of Ball Memorial Hospital BB, Muncie.
Indianapolis	Community Blood Bank of Marion County, Inc., 2128 N. Meridian St. (46202) Community Hospital Blood Bank, 1500 N. Ritter Ave. (46219) Indiana University Medical Center Blood Bank, 1100 W. Michigan St. (46207) Marion County General Hospital Blood Bank, 960 Locke St. (46207) Methodist Hospital Blood Bank, 1604 N. Capitol Ave. (46207) St. Vincent's Hospital Blood Bank, 120 W. Fall Creek Parkway (46207)	Coordinator bank. Affiliate of Community BB of Marion County, Inc., Indianapolis. Affiliate of Community BB of Marion County, Inc., Indianapolis.
Lafayette	Winona Memorial Hospital Blood Bank, 3202 N. Meridian St. (46208) Lafayette Home Hospital Blood Bank, 2400 South St. (47904) St. Elizabeth Hospital Blood Bank, 1501 Hartford St. (47904)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Linton	Freeman Greene County Hospital Blood Bank, 410 A St., N.E. (47441)	Affiliate of Union Hospital BB, Terre Haute.
Marion	Marion General Hospital Blood Bank, Wabash and Euclid Aves. (46952)	
Muncie	Ball Memorial Hospital Blood Bank, 2401 University Ave. (47303)	Coordinator bank.
New Castle	Henry County Hospital Blood Bank, 1000 N. 16th St. (47362)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Noblesville	Riverview Hospital Blood Bank, State Road 32 (46060)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Richmond	Reid Memorial Hospital Blood Bank, (47374)	Affiliate of Community BB of Marion County, Inc., Indianapolis.

<i>City</i>	<i>Blood Bank and Address</i>	<i>Comments</i>
Rushville	Rush Memorial Hospital Blood Bank, 13th and Main St. (46173)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Shelbyville	W. S. Major Hospital Blood Bank, 150 W. Washington St. (46176)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
South Bend	Central Blood Bank, Inc., 204 W. Navarre St. (46601)	
Terre Haute	St. Anthony Hospital Blood Bank, 1021 S. Sixth St. (47807) Union Hospital Blood Bank, 1606 N. Seventh St. (47804)	Coordinator bank.
Tipton	Tipton County Memorial Hospital Blood Bank, 1032 S. Main St. (46072)	Affiliate of Community BB of Marion County, Inc., Indianapolis.
Vincennes	Good Samaritan Hospital Blood Bank, 410 S. Seventh St. (47541)	
MARVIN E. PRIDDY, M.D., <i>Chairman</i>	JOHN E. FREED, JR., M.D.	ADOLPH WALKER, M.D.
JOSEPH E. COLEMAN, M.D.	JOHN SMITH, M.D.	ROBERT M. BROWN, M.D.
NORBERT M. WELCH, M.D.	HAROLD C. OCHSNER, M.D.	JAMES D. KUBLEY, M.D.
ELI GOODMAN, M.D.	HENRY BIBLER, M.D.	K. G. HILL, M.D.
ROBERT O. ZINK, M.D.	CLARENCE G. KERN, M.D.	WES SHANNON, M.D.

Aging

The commission met twice during the 1966-1967 calendar year. During the course of their sessions the commission voted to oppose Senate Bill 189, which was before the State Legislature, and would have established a sovereign body with the authority to make rules and regulations concerning all matters of the aged in Indiana. The commission voted to support House Bill 1400, which would keep programs of the aged firmly within the responsibility of the Indiana State Medical Association and the Indiana State Board of Health.

At the direction of the commission, a letter was sent to Doctor Bowen, Speaker of the House of Representatives, and a copy of the letter to the Governor and to Doctor Schuster, chairman of the Commission on Legislation, noting the commission's position on these matters. Neither bill passed.

The final report of the Independent Living Study was prepared and distributed by the Indiana State Board of Health. The study had been participated in and endorsed by the Commission on Aging of

the Indiana State Medical Association, and in conjunction with the Indiana State Board of Health, had been prepared for the Indiana Legislative Advisory Commission.

Dr. George Young, vice-chairman of the commission, represented the Indiana State Medical Association, October 4th and 5th, 1966, in a program at Purdue University entitled "Counseling of Older Persons." Dr. Young discussed the need for physical health counseling. The conference was held under the direction of Dr. George E. Davis, executive director of the Indiana Commission on Aging and Aged.

During the course of the commission's deliberations, Doctor Offutt, State Health Commissioner, reported to the Commission on Aging on several matters. He emphasized that state legislators needed facts from authoritative sources in passing good legislation. He pointed out that policies established by the Commission on Aging had aided in passage of much good legislation in various areas and that such policies have done a great deal to influence good

programs for the aged in Indiana.

He expressed the opinion that the commission should continue to formulate policies on matters, as they arose, to give authority to appropriate bodies and to the legislature to initiate laws and new programs and continue the conduct of established programs for the aged.

GLEN A. RAMSDELL, M.D.,

Chairman

GEORGE M. YOUNG, M.D.,

Vice-Chairman

BERNARD B. ROSENBLATT, M.D.,

Secretary

C. PHILIP FOX, M.D.

WALTER S. FISHER, M.D.

A. W. CAVINS, M.D.

JOHN O. BUTLER, M.D.

RALPH R. PLOUGHE, M.D.

WALLACE R. VANDENBOSCH, M.D.

GEORGE W. WAGONER, M.D.

NATHAN SALON, M.D.

DONALD T. OLSON, M.D.

ANDREW C. OFFUTT, M.D.

WENDELL C. ANDERSON, M.D.

RAY DUNCAN, M.D.

Resolutions

Amendments to the Constitution to be Voted on at Indianapolis Session, 1967

At the 1966 annual convention at French Lick, the House of Delegates adopted the report of the Reference Committee on Amendments to the Constitution and By-laws, in which the reference committee recommended for adoption the following two amendments to the Constitution: (Words or sections added are italicized).

(1) Amend Article IV, Section 2, of the Constitution by inserting after the word "the" in the last line the following words, "*district medical society and in*", which would make this section read as follows:

"Sec. 2—**Active Members**—The active members of this association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis

that does not include membership in the *district medical society and in the Indiana State Medical Association.*"

(2) Amend Article VII of the Constitution by inserting after the words, "such societies to be composed exclusively of" and before the word, "members" the word "*all*" which would make the article read as follows:

"**ARTICLE VII — SECTIONS AND DISTRICT SOCIETIES** — The House of Delegates may provide for a division of the scientific work of the association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of *all* members of component county societies. Councilor districts shall be defined by the House of Delegates."

Resolution No. 67 - 1

Introduced by: CLAY COUNTY
MEDICAL SOCIETY
Subject: MEMBERSHIP OF
DISABLED PHYSICIANS

WHEREAS, there is no provision in the Constitution and Bylaws of the Indiana State Medical Association for continuing membership of those physicians, who by their own admission are deemed to be permanently disabled, except for remission of their dues, and,

WHEREAS, such remission of dues has many of the aspects of charity, and,

WHEREAS, such procedure has a demoralizing effect on the disabled physicians and approaches professional abandonment of such physicians by his colleagues and his association,

NOW THEREFORE BE IT RESOLVED, that an additional classification of membership be added to those already in force and that such physicians receive membership cards and *The Journal of the ISMA* the same as regular members and without charge. Proof of such disability shall be by notification of the secretary of the association by the secretary of the county society in which the physician has held membership.

(CHAPTER XXVII, Sec. 12, Paragraph 4).

Abstracts of Educational Films to be Shown at ISMA Convention

CANCER IN CHILDREN (27 minutes)

The film discusses the case of a child with Wilm's Tumor presented to the Tumor Board by the patient's physician. The detection of the tumor, diagnostic procedures and findings, and the management are described. The film deals in terms with cases of neuroblastoma, intracranial neoplasms, leukemia and rhabdomyosarcoma. In each case, the significant features of the disease are given; its natural history, frequency, differential diagnosis, management and prognosis.

DIAGNOSIS AND MANAGEMENT OF CANCER OF THE COLON AND RECTUM (17 minutes)

The film demonstrates the diagnosis and treatment of both symptomatic and asymptomatic cancer of the colon and rectum; shows endoscopic motion pictures of malignant lesions and of the healthy colon; brings out the inadequacy of the digital examination alone, and stresses the importance of routine procto-

sigmoidoscopy and the guaiac test for asymptomatic patients supplemented by barium enema when indicated. The film demonstrates the principles of surgery for cancerous lesions of the colon and rectum and emphasizes the importance of early diagnosis before symptoms occur, in improving survival rates of the most common of all internal cancers.

NURSING MANAGEMENT OF THE PATIENT WITH CANCER (29 minutes)

The film shows in detail the nursing procedure used when patients experience laryngectomy, tracheotomy, colostomy or cystectomy.

ORAL CANCER (22 minutes)

The film demonstrates a systematic five-minute visual and digital exam for cancer as part of the routine and physical examination of an asymptomatic patient. Color motion pictures and still photographs of various oral lesions are shown.

TUMORS OF THE MAJOR SALIVARY GLANDS (15 1/2 minutes)

The film illustrates the differential diagnosis and management of tumors of the major salivary glands; parotid, submaxillary and sublingual. A relative incidence of the various neoplastic lesions of these glands is listed. The indications and contraindications for biopsy are covered and the principles of surgery and end results of treatment are recorded.

Scientific Exhibits

RICHARD B. HOVDA, M.D., Evansville, Chairman

CANCER OF THE SKIN AND MUCOUS MEMBRANE

Exhibitors: Edwin E. Pontius, M.D., and James H. Gosman, M.D., Methodist Hospital Graduate Medical Center, Indianapolis

Co-exhibitor: American Cancer Society, Indiana Division, Inc.

Attendants: The exhibitors and Mr. Allan Erickson

Early recognition and institution of ablative therapy can cure cancer of the skin and mucous membrane. Early recognition of cancer of these tissues by the physician, dentist, nurse and pharmacist, as well as by the patient himself, is necessary before proper diagnostic and therapeutic steps are taken.

The exhibit illustrates typical instances of the most common skin and mucous membrane malignancies. It presents data on causative factors, preventative measures and general therapeutic considerations.

INDIANA CHAPTER FLYING PHYSICIANS ASSOCIATION

Exhibitor: Indiana Chapter, Flying Physicians Association

Attendants: Dan L. Urschel, M.D., Robert Reed, M.D., William Dannacher, M.D.

DOSE RESPONSE: KEY TO EFFECTIVE TREATMENT

Exhibitor: Fred J. Phillips, M.D., Quakertown, Pa.

Co-exhibitors: David M. Shoemaker, M.D., C. L. Chai, M.D., M. D. Debuque, M.D.

Attendant: Fred J. Phillips, M.D.

A large segment of patients with arthritis, musculoskeletal and inflammatory problems seen in today's general practice respond with more predictable results when effective therapy is coupled with a careful dosage program.

A comprehensive management program and the results of our experience with 281 patients over a period of three years employing short as well as long term therapy

is presented.

The schedule employed to effect a dose reduction to the smallest maintenance level, thus affording an economic advantage to the patient, is outlined.

COMMUNICATION IN ANESTHESIOLOGY

Exhibitor: Dean H. Morrow, M.D., Anesthesiology Department, University of Kentucky Medical Center, Lexington, Kentucky

Co-exhibitors: Ian C. Bennett, D.D.S., Peter P. Bosomworth, M.D., Michael T. Romano, D.D.S.

Attendants: Dean H. Morrow, M.D., and two video technicians

The key to the educational process is the communication of knowledge from mind to mind. Just as we have seen advances in other types of human endeavors, we are in the midst of significant changes in educational modalities based primarily on better knowledge transmission. Teaching anesthesiology can be enhanced by the utilization of one of the most important, relatively new communication mediums—television and videotape.

INDIANA UNIVERSITY MEDICAL CENTER MEDI-TAPE REVIEWS

Exhibitor: Dean's Office, Indiana University Medical Center, Indianapolis

Attendants: Seymour Friedberg, Ralph Nye, Ollie Craig

A reel of videotape containing 10-12 short episodes of interesting events, new techniques and knowledgeable persons at the Indiana University Medical Center will be presented. This will be replayed continuously during convention hours. A 25" black and white TV monitor will be framed in a 2' x 8' sheet of prefinished paneling. The front will carry a supply of program cards concerning the videotape being used. A supply of request cards will also be displayed, as well as a receptacle into which they may be placed. Videotapes and data cards may be replaced daily during the convention.

STUDIES IN INFANT FEEDING:

Incidence of Colic and Gastrointestinal Disturbances

Exhibitor: Lawrence Breslow, M.D., Chicago, Ill.

Co-exhibitor: Lutheran General Hospital, Chicago, Ill.

Attendant: Lawrence Breslow, M.D.

A previous study of infants on artificial formulas has revealed that disturbances of the gastrointestinal tract, especially colic, are frequently due to an inability to tolerate the fats or carbohydrate in these feedings. This is true especially after poor feeding technic, hunger and pathological entities are ruled out as etiological factors.

A unique double-blind crossover, in 127 infants, compared the acceptance of a standard evaporated milk and carbohydrate formula with a uniquely modified low casein and lower protein feeding. The formulas were alternated at 21-day intervals and reports were obtained at each alternation or more often on acceptability, regurgitation, frequency and characteristics of the stools, and the presence of any disturbing gastrointestinal symptoms.

The study revealed that, although a majority of infants accepted both formulas equally well, the low casein and lower protein formula was found to cause many fewer gastrointestinal disturbances.

A GENERAL HOSPITAL APPROACH TO COMMUNITY MENTAL HEALTH

Exhibitor: H. H. Garner, M.D., Professor and Chairman, Department of Psychiatry and Neurology, The Chicago Medical School—Mount Sinai Hospital, Chicago, Ill.

Co-exhibitors: Marshall A. Falk, M.D., The Chicago Medical School—Mount Sinai Hospital Medical Center, Chicago, and Albert H. Feinerman (above address)

Attendant: M. A. Falk, M.D.

A study of over 2,300 patients admitted to a 28-bed psychiatric unit of a general hospital over a five-year period. It is the purpose of the exhibit to show that the

community general hospital can and should be the focus for the handling of community mental health problems. Using an electric approach and no discrimination as to the type of case accepted, an analysis of the five years (1961-65) showed an average length of stay of 18 days with a readmission rate of 15%. Both of these figures are lower and are compared with lengths of stay of common medical illnesses. The statistics are shown in graph and picture form with the use of slides. The method by which these results were obtained is shown by a seven fold approach to the problem. It includes: Inpatient, Outpatient, Day Hospital, Vocational Home Care and Continuing Education for the Family Physician. Each of these modalities is shown in the form of a flow sheet. The progress of a patient from a disruptive situation through his hospital course and post-discharge course is shown.

A DESIGN FOR LIVING

Exhibitor: Logansport State Hospital, Logansport
Attendants: Mrs. Ann Cook and Mrs. Alice Reeves, R.N.

The purpose of this exhibit is to show that regression in chronic schizophrenics can be reversed and that patients will improve enough to be discharged or productive.

Patients are between the ages of 40 to 55 and have been in the hospital from five to 15 years. They are equally divided in their sexes. Each patient was evaluated as to mental status. Different psychological tests were done. The ward was improved by putting in attractive communal facilities. Patients have individual rooms and wardrobes. Lighting was also improved, and patients have privacy. The rehabilitative program consisted of personal attention and acceptance of the patient as an individual. A potential for social exchange was available at all times. Male and female patients used the same living room, kitchen and dining room but have separate dormitories in the same building. Patients have a free choice of activity programs made through patient government's numerous committees.

After a year or more several patients were discharged. Some patients were on a night hospital status, working in nearby towns but coming to the hospital at night. All-in-all there was an improvement in the way they took care of themselves and the way they socialized.

This program is being presented with pictures, posters and a self-contained slide show with descriptions heard through ear-phones.

CONGENITAL DEFORMITIES OF THE CHEST WALL

Exhibitor: Mark M. Ravitch, M.D.,
 University of Chicago—
 Wyler, Chicago, Ill.

The exhibit demonstrates color transparencies and radiologic transparencies of patients with four principal types of chest wall defects before and after operation. The four types are 1.) Depression deformities of the sternum; 2.) Protrusion deformities of the sternum; 3.) Clefts of the sternum and 4.) Rib deformities. Large scale drawings show the operative technics for the principal types in each category.

1.) Depression deformities of the sternum (pectus excavatum, funnel chest) are congenital, often familial, usually progressive, and are marked by a depressed or concave sternum, frequently twisted to the right, protuberant abdomen, dorsal kyphos, forward thrust head, rounded shoulders and paradoxical inward motion of the sternum on inspiration. In infancy, the condition appears to be asymptomatic although we have had a few infants with severe symptoms. In childhood, many of the children are underweight and show a decrease in vigor and capacity for exercise. This continues throughout life and in young adult life, an occasional individual develops incapacitating cardiorespiratory disability, sometimes even to the point of cardiac failure. Operative correction consists in resection of the deformed costal cartilages, subperichondrially, xiphi-sternal disarticulation, division of the intercostal bundles, posterior sternal osteotomy and maintenance of the corrected position by suture and bone block without external traction or fixation. The results have been good, have been maintained over the years, and in over 200 operations, there has been a single death and that 20 years ago.

2.) Protrusion deformities of the sternum (pigeon breast, chicken breast). The deformity may appear to be quite grotesque. The chicken breast variety is accentuated by its most significant component, which is a depression of the costal cartilages running down either side of the sternum, decreasing the intrathoracic space and preventing normal excursion of the chest wall with respiration. Subperichondrial resection of the depressed cartilages with reconstruction of the sternum added in a few cases provides a satisfactory correction.

3.) Cleft sternum. A. Upper (cervicothoracic ectopic cordis) B. Lower (thoracoabdominal ectopic cordis) usually associated with a pentalogy of defects: 1.) Distal sternal cleft 2.) Ventral abdominal wall omphalocele-like defect 3.) Ventral diaphragmatic defect 4.) Defect

of diaphragmatic face of pericardium 5.) Ventricular septal defect C. Complete sternal cleft. In early infancy, direct closure of the defects is possible. Later in childhood, prosthetic reconstruction may be required.

4.) Congenital absence of costal cartilages, II, III, IV with absence of costal portion of pectoralis major, pectoralis minor and absence or hypoplasia of the breast and subcutaneous tissue. There is a marked area of paradox. The deformity tends to be progressive and operation is performed using rib grafts and a sheet of prosthetic material.

INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS — "DOES YOUR GIRL BELONG?"

Exhibitor: Mrs. Lorraine Herres,
 President, Indiana State
 Association of Medical
 Assistants, Marion, Ind.
Co-exhibitor: Mrs. Nellie Jones, Rolling
 Prairie, Ind.
Attendants: Mrs. Jones and other
 medical assistants

The primary interest and purpose of the American Association of Medical Assistants and the I.S.A.M.A. is to help medical assistants increase their knowledge and become better assistants for the doctor and his patients. The organization is a non-profit organization, not a trade union or collective bargaining agency. It is approved by the American Medical Association.

Meetings are held to exchange ideas on office procedures and to hear educational and stimulating talks by physicians from the various fields of medicine. The group believes better trained assistants can assume more responsibility toward maintaining smoothly running offices.

PREVENTION OF POSTOPERATIVE INTESTINAL ADHESIONS — EXPERIMENTAL AND CLINICAL STUDIES

Exhibitor: Robert L. Replogle, M.D.,
 University of Chicago
 School of Medicine, Chicago, Ill.
Attendants: Helmut Kundler, Robert
 L. Replogle, M.D.

A method for the prevention of post-operative intestinal adhesions is presented, based on consideration of the pathophysiology of adhesion formation. By the use of an antihistamine, promethazine, and an adrenal cortical hormone, dexamethasone, the inflammatory phase that follows trauma to the intestinal serosa can be minimized, and the organization of inflammatory exu-

date into fibrous adhesions can be delayed. This delay allows serosal cells to grow over the denuded area of bowel and thus cover any raw fibromuscular surfaces which otherwise could be the seat of adhesion formation. Results of experimental studies in 150 dogs and a series of nearly 80 patients have been uniformly encouraging.

DISORDERS OF THE HIP (Various methods of surgical treatment)

Exhibitor: Palmer Eicher, M.D., Associate Professor of Orthopedic Surgery, Indiana University School of Medicine, Indianapolis

Attendants: Palmer Eicher, M.D., David Tillema, M.D.

- 1) Degenerative joint disease (cox arthrosis) varied etiology
 - a) Primary:
 - E. C. 1) osteotomy
 - 2) Luck mold
 - b) Coxa malum sinilis:
 - R. B. 1) Luck mold
 - c) Osteoporotic sinking hip:
 - M. R. 1) Composite mold
 - Complication—fracture
 - 2) Prosthesis
- 2) Neglected fracture:
 - E. C. 1) Prosthesis (18 year follow-up)
- 3) Fracture, union, avascular necrosis:
 - P. B. 1) Prosthesis
- 4) Fracture, non-union, avascular necrosis:
 - T. G. 1) Prosthesis
- 5) Rheumatoid hip:
 - a) T. E. 1) Prosthesis
 - b) A. C. 1) Luck mold, bilateral

The exhibit includes nine brief case histories. A short history and development of a prosthesis which I designed 20 years ago will be included. Information obtained from a harvested hip also will be included to show why all the implants currently used by me are made of commercially pure titanium.

COMING IN INDIANA! MENTAL HEALTH CENTERS

Exhibitor: Indiana Mental Health Planning Commission, Indianapolis

Attendants: Mrs. Rosemary Lewis, Information Director, and Daniel D. Steiner, Assistant Director, IMHPC

This exhibit describes the development of community mental health centers in our state and portrays them as a helping resource for private physicians. Side panel

tells how the Knox County Medical Society launched a community fund drive for a mental health center in Vincennes. The table-top display is a model of this project: the new Good Samaritan Hospital (under construction) with its entire second floor housing a three-county mental health center. Another panel pinpoints locations for a total of 31 such centers in Indiana; most will be based in, or affiliated with, community general hospitals.

A HOSPITAL BASED ECPR PROGRAM: EMERGENCY RESUSCITATION TEAM

Exhibitor: Indiana Heart Association, Inc.

Attendants: Earl B. Beagle, David Livengood, William Dudley, Frederic Weigle

This four-panel unit, a table-top display in color, is directed primarily at hospitals. It stresses the importance of an emergency resuscitation team, a community plan for resuscitation and the availability of an adequate training program in the hospital.

This display was prepared by the Committee on Cardiopulmonary Resuscitation of the AHA.

YOUR SOURCE FOR PRESCRIBING INFORMATION . . . THE PHARMACIST

Exhibitor: Indiana Pharmaceutical Association

Attendants: James D. Hawkins, R. Ph., William L. Long, R. Ph.

The Indiana Pharmaceutical Association exhibit will illustrate that the pharmacist of today serves the medical profession as a ready source for prescribing information. The health education function of the pharmacist is growing and the exhibit will show a current display rack program designed to make approved literature on health matters available to the public through pharmacies. Some of the modern professional practices of pharmacists will also be shown, including family prescription records.

TWO FACES OF SUEMMA COLEMAN HOME—CONCERN FOR UNWED MOTHERS AND CHILDLESS COUPLES

Exhibitor: Suemma Coleman Home, Indianapolis

Attendants: Marie Wetzel, Betty Hughes, Mary Jo Mozingo, Emily Wiggs

Suemma Coleman Maternity Home is an Indianapolis United Fund agency, which

has a dual concern to serve the unwed mother and the childless couple. Thus, the idea of the two faces of Suemma Coleman was created. The agency was founded in 1894 and has maintained a high standard of service to both resident girls and to adoptive couples.

Throughout the years, a steady number of referrals have come to us from doctors. It is quite understandable that families with a problem turn to a *key* person in their community. Their doctor, who in many instances, is also a family friend and counselor, is often this *key* person. We believe that throughout the Hoosier state, Suemma Coleman has a large circle of friends and acquaintances among physicians, but it is our desire to increase this number and to strengthen the relationships and bonds already formed.

We hope that at this annual convention of the Indiana State Medical Association, we will have opportunity to interpret our service through literature and our personal exhibit contacts with the physicians of Indiana.

TRAFFIC DEATHS IN LAKE COUNTY

Exhibitors: W. P. Loh, M.D., Chief Pathologist; A. S. Williams, M.D., Coroner, Office of Lake County Coroner, Gary

Attendants: Exhibitors or a well informed person to be designated later.

Motor vehicle accidents continue to be the leading cause of death for our young citizens. About every ten minutes, there is a traffic death. Last year, 52,000 Americans died in motor vehicle accidents. There have been 1.5 million deaths since 1899 when the first traffic death was recorded. This serious problem has caused us great concern and motivated us to make an annual analysis of the traffic deaths in our county.

This exhibit presents a statistical study of the 1965 and 1966 traffic deaths in Lake County. Tables are used to analyze the time and day of fatal accidents, the cause of accident, the type of fatality, age and sex of the victims and the major cause of death. Still and motion models are used to illustrate the causes of fatal accidents. The illustration is further aided by photographs. Frequency of alcohol intoxication is analyzed. Recommendations for traffic safety are given.

MEDIASTINOSCOPY—A PRACTICAL DIAGNOSTIC TECHNIQUE

Exhibitor: Harry Siderys, M.D.,
Indianapolis
Co-exhibitor: John N. Pittman, M.D.,
Indianapolis

Mediastinoscopy, as it is practiced today, was first described by Carlens in 1959. The procedure is done through a short transverse incision over the suprasternal notch. After identification of the trachea, it is used as a guide into the mediastinum. Paratracheal nodes can be palpated digitally, manipulated, and biopsied as far distally as the carina.

This technique is of great value in determining the degree of spread of centrally located carcinoma of the lung, particularly in those patients with poorly differentiated lesions and in patients who are poor surgical risks. It is also of help in identifying the benign causes of parahilar adenopathy such as sarcoidosis or reactive hyperplasia.

Drawings, charts and the instruments used will be exhibited.

MEDICINE AND RELIGION

Exhibitor: Department of Medicine
and Religion of the
American Medical Association
Attendant: Robert Coons

The purpose of this exhibit is to present the program of the AMA Department of Medicine and Religion to the physicians in attendance and afford the opportunity of discussing some of the topics involved in this program. Some of these topics are abortion, contraceptives, drug addictions, ethical and moral implications of modern "machine" medicine and the care of the terminal cancer patient.

The purpose of the program, both at the national and local medical society level, is to promote communication between the two professions to effect total patient care.

SUPPLEMENTAL IRON NEEDS IN THE OBSTETRIC PATIENT

Exhibitor: James B. Martin, M.D.,
Albany, Georgia
Attendant: James B. Martin, M.D.

The exhibit presents the various causes of iron deficiency in the female and particularly the need of supplemental iron

during pregnancy, the results of a clinical investigation over a period of five years and a discussion of comparative hemoglobin values resulting from the supplemental administration of ferrous fumarate and ascorbic acid. Emphasis is placed not only on the maintenance of acceptable hemoglobin levels but with restoring the depleted iron storage often resulting from multiple pregnancies. Other aspects of anemia of pregnancy are discussed.

"G. P. CLUB"

Exhibitor: Indiana Academy of
General Practice

The Indiana Academy of General Practice exhibit will explain, in detail, the purpose of the General Practice Club in Indiana. This club was initiated two years ago and has functioned with monthly meetings for all four classes of medical students. Total student membership to date is 350. Dean Irwin and the Indiana University faculty have cooperated in every way possible to help make our program successful. The primary purpose of the club is to introduce the students to the general practice of medicine as they have so few contacts with general practitioners or the general practice of medicine on campus.

Technical Exhibitors—1967

(Letter prefix denotes aisle).

ABBOTT LABORATORIES Booth L-5
14th and Sheridan Rd.
North Chicago, Ill. 60064

AKRON SURGICAL HOUSE, INC.
Booths B-3 & B-5
1927 N. Capitol Ave.
Indianapolis, Ind. 46202
Jim Buehler, Ed Hallyburton and
Clarence Lippott

ALOE MEDICAL Booth B-14
1831 Olive St. St. Louis, Mo. 63103
Nick Belfiglio and Dick Hazelwood

AMES COMPANY Booth C-22
1127 Myrtle St. Elkhart, Ind. 46514
Dwight A. Gosling, John Q. Neal and
R. L. Jackson

APACHE OIL PROGRAMS, INC.
Booth D-9
1800 Foshay Tower
Minneapolis, Minn. 55402
J. D. Hawson and Matt C. Hoy

ARNAR-STONE LABORATORIES,
INC. Booth D-1
501 E. Kensington Rd.
Mt. Prospect, Ill. 60058
J. F. "Pete" Surratt

ASTRA PHARMACEUTICAL
PRODUCTS, INC. Booth D-12
7 Neponset St. Worcester, Mass. 01606
David E. DeWine

AUTOMATED MANAGEMENT
SYSTEMS, INC. Booth C-12
5016 Knoll Crest Court
Indianapolis, Ind. 46208
Charles E. Kile and Martha Kile

AYERST LABORATORIES Booth D-7
585 Third Ave. New York, N. Y. 10017

BAKER BROTHERS SALES &
RENTALS Booths C-24 & C-26
2039 N. Capitol Ave.
Indianapolis, Ind. 46202
Mr. and Mrs. Frank M. Jones,
Tom Jones and Terry Jones

BEECHAM RESEARCH
LABORATORIES Booth B-15
585 Third Ave. New York, N. Y. 10017
Thomas J. Wise and Thomas L. Houk, Jr.

BLACK & SKAGGS ASSOCIATES,
INC. Booth L-7
181 North Ave.
Battle Creek, Mich. 49017
Paul Evans, Harold L. Neff, Jack Osborn,
George White and Tommy Gregg

BRISTOL LABORATORIES
Booth D-15
P. O. Box 657 Syracuse, N. Y. 13201

BURROUGHS WELLCOME & CO.
(U.S.A.) INC. Booth L-3
1 Scarsdale Road Tuckahoe, N. Y. 10707

BUSINESS FURNITURE
CORPORATION Booths B-11 & B-13
101 S. Pennsylvania St.
Indianapolis, Ind. 46204

James W. Weir, Phyllis Zabel, Janice
LaPlant, Jane Campbell, Judy Atkins,
John Ober, Bob Apple, Charles Winton,
Ron Schuetter, Buzz Hamby, Bob Baugh-
man, Bob Wilson, Ralph Maus, Joe Scho-
field, Geneva Boggs, Dean Arnold, Joe
Sights, Bob Brand, Gerry Lakin and
R. M. Clymer.

CENTRAL BRACE AND LIMB
COMPANY Booth C-23
1901 N. Capitol Ave.
Indianapolis, Ind. 46202

CIBA PHARMACEUTICAL
COMPANY Booth D-20
556 Morris Ave. Summit, N. J. 07901
R. K. Kitterman and H. F. Radtke

THE COCA-COLA COMPANY
Booth B-25
P. O. Drawer 1734 Atlanta, Ga. 30301

CORECO RESEARCH
CORPORATION Booth D-17
159 West 25th St. New York, N.Y. 10001
William Zimmerman

CURTIS AND FRENCH, INC.
Booth C-3
444 W. 16th St. Indianapolis, Ind. 46202
Don Graves, Jack Curtis and Roy Watts.

DAIRY COUNCILS OF INDIANA
Booth C-13
Evansville, Indianapolis, South Bend
Mrs. Lillian Staub, Mrs. Bernice Shriner,
Mrs. Hazel Burnett

DICTAPHONE CORPORATION
Booth C-16
3530 Washington Blvd.
Indianapolis, Ind. 46205

THE DOW CHEMICAL COMPANY
Booths D-11 & D-13
P. O. Box 512 Midland, Mich. 48640

ENCYCLOPAEDIA BRITANNICA,
INC. Booth D-10
425 N. Michigan Ave. Chicago, Ill. 60611
C. Cobb, R. Oglesby, J. Parker,
V. Walsh and E. Raffey

ESTA MEDICAL LABORATORIES,
INC. Booth D-16
401 Joyce Kilmer Ave.
New Brunswick, N. J. 08902
M. Ruskin

FLINT LABORATORIES Booth B-1
6301 Lincoln Ave.
Morton Grove, Ill. 60053
W. Lukanovich

GEIGY PHARMACEUTICALS
Booth B-4
444 Saw Mill River Rd.
Ardsley, N. Y. 10502

GERBER PRODUCTS COMPANY
Booth C-1
445 State St. Fremont, Mich. 49412
Joseph P. Madigan and Derrick Harris

IMPERIAL FASHION Booth D-19
1224 W. Santa Barbara Ave.
Los Angeles, Calif. 90037

INDIANA BELL TELEPHONE
COMPANY Booth D-3
240 N. Meridian St.
Indianapolis, Ind. 46209

INDIANA BRACE SHOP, INC.
Booth B-24
72 W. New York St.
Indianapolis, Ind. 46204

INDIANA NATIONAL BANK
Booth L-4
3 Virginia Ave. Indianapolis, Ind. 46204
John H. Kealing, George W. Eggleston,
Harry A. Sommer, Perry H. O'Neal and
Calvin B. Howard

INDIANA SURGICAL, INC.
Booth B-23
5541 E. Washington St.
Indianapolis, Ind. 46219

LEDERLE LABORATORIES
Booth C-15
Middletown Rd. Pearl River, N. Y. 10965
J. E. Berck, M. T. Drew, N. B. Hugus,
T. J. Meier and F. M. White

LEMMON PHARMACAL COMPANY
Booth D-14
Box 30 Sellersville, Pa. 18960
George Megnin, Don Hoover,
Elmer Wychoff, Willis Thomas and
Gary Riley

ELI LILLY AND COMPANY Booth B-2
P. O. Box 618 Indianapolis, Ind. 46206
N. L. Stephenson and P. A. Holsapple

J. B. LIPPINCOTT COMPANY
Booth L-6
E. Washington Square
Philadelphia, Pa. 19105
Richard Wright

LOMA LINDA FOODS Booth C-9
Riverside, Calif. 92505

P. LORILLARD COMPANY**Booth D-22**

200 East 42nd St. New York, N. Y. 10017
M. L. Baker and R. E. Larry

MARION LABORATORIES, INC.**Booth D-18**

10236 Bunker Ridge Rd.
Kansas City, Mo. 64137

McNEIL LABORATORIES, INC.**Booth C-18**

Camp Hill Rd.
Fort Washington, Pa. 19034

MEAD JOHNSON LABORATORIES**Booth C-6**

2404 Pennsylvania St.
Evansville, Ind. 47721

MEDCO PRODUCTS COMPANY, INC.**Booth D-23**

3601 E. Admiral Place, P. O. Box 50070
Tulsa, Okla. 74150
Jim Shores, Jess Fink and Bruce Jarvie

THE MEDICAL PROTECTIVE COMPANY**Booth B-6**

Station "A", Box 2021
Fort Wayne, Ind. 46805
Kenneth W. Moeller and
Phillip P. Capasso

MERCK SHARP & DOHME**Booth D-21**

West Point, Pa. 19486

T. P. Moriarty, P. E. Furnish,
D. C. Abbitt and W. N. Miller

MERRILL LYNCH, PIERCE, FENNER & SMITH**Booth R-2**

111 E. Market St. Indianapolis, Ind. 46204

MODERN DRUGS, INC.**Booth A-14**

4202-04 E. New York St.
Indianapolis, Ind. 46201

Kenneth E. Hoy, Jr., and
Kenneth E. Hoy, Sr.

MUTUAL MEDICAL INSURANCE, INC.**Booth C-20**

(Indiana Blue Shield Plan)
110 N. Illinois St. Indianapolis, Ind. 46209
Herbert P. Dixon, Frederick D.
Harbridge and Richard C. Kilborn

NORTH AMERICAN PHARMACAL, INC.**Booth A-2**

6851 Chase Rd. Dearborn, Mich. 48126

ORTHO PHARMACEUTICAL CORPORATION**Booth L-9**

Raritan, N. J. 08869

PARKE, DAVIS & COMPANY**Booth B-17**

Joseph Campau Ave. at the River
Detroit, Mich. 48232
D. O. Lamport and A. H. Griffin

PFIZER LABORATORIES**Booth C-10**

235 E. 42nd St. New York, N. Y. 10017

WM. P. POYTHRESS & CO., INC.**Booth D-8**

P. O. Box 2158 Richmond, Va. 23217
Robert W. Houser and Sam M. Pope

QUAKER CITY PHARMACAL COMPANY**Booth B-9**

1034 South 54th St.
Philadelphia, Pa. 19143

R. J. REYNOLDS TOBACCO COMPANY**Booth B-7**

Winston-Salem, N. C. 27102
A. G. Carlson, Louis Iauco and
T. E. Marsh

A. H. ROBINS COMPANY**Booth C-4**

1407 Cummings Dr. Richmond, Va. 23220
Bill Spangler, Bob Troke, Mike Sifferlen
and Marshall Etherington

SANDOZ PHARMACEUTICALS**Booth B-12**

Route No. 10 Hanover, N. J. 07936
Richard Sapp, Bob Sexton,
Ken McCall and Lee Linton

W. B. SAUNDERS COMPANY**Booth D-5**

7th and Locust St.
Philadelphia, Pa. 19105
Neil Rowe

SCHERING CORPORATION**Booth C-2**

1011 Morris Ave. Union, N. J. 07083
Edwin Leinhos, William Rosner,
Robert Cunningham and Rollan Perry

CLAYTON L. SCROGGINS ASSOCIATES**Booth B-18**

141 W. McMillan St.
Cincinnati, Ohio 45219

G. D. SEARLE & CO.**Booth L-1**

P. O. Box 5110 Chicago, Ill. 60680
W. H. Meyer, R. E. Fritz,
R. W. Schulz and D. B. Wharmby

SEVEN-UP BOTTLING COMPANY, INC.**Booth C-25**

651 E. 20th St. Indianapolis, Ind. 46202

SIEMENS MEDICAL OF AMERICA, INC.**Booth C-14**

60 West Fay Ave. Addison, Ill. 60101

SMITH KLINE & FRENCH LABORATORIES**Booth D-31**

1500 Spring Garden St.
Philadelphia, Pa. 19101
Edward D. Porter, James H. Troyer,
F. James Forbregd and James A. Bova

SMITH, MILLER & PATCH, INC.**Booth L-2**

902 Broadway New York, N. Y. 10010
Kenneth Long and Larry Roberts

SPENCER CORSET SHOP**Booth B-21**

314 Hume Mansur Bldg.
Indianapolis, Ind. 46204

Doris Thompson, Fred Moynahan,
Mona Nevit and Mildred Ulrich

E. R. SQUIBB AND SONS**Booth C-17**

745 Fifth Ave. New York, N. Y. 10022

STRYKER CORPORATION**Booth B-8**

420 Alcott St. Kalamazoo, Mich. 49001
John A. Clarke, Marion H. Clarke and
Jim Snyder

THE STUART COMPANY**Booth B-26**

3360 E. Foothill Blvd.
Pasadena, Calif. 91107

John W. Nichol, Jr., and
Robert W. Smith

SYNTEX LABORATORIES, INC.**Booth D-30**

3401 Hillview Ave. Palo Alto, Calif. 94304
John Wolverter, J. R. Van Aman and
Fremont E. Young

THOMSON & McKINNON**Booth D-4**

200 Circle Tower Bldg.
Indianapolis, Ind. 46204

Herman Uebele, John Triller, John
Stimson and John Kixmiller

3M BUSINESS PRODUCTS SALES, INC.**Booth D-2**

2445 E. 54th St. Indianapolis, Ind. 46220

TRI-STATE MEDICAL**ELECTRONICS, INC. Booth B-19**

5102 W. 79th St. Indianapolis, Ind. 46268

S. J. TUTAG & COMPANY**Booth D-6**

19180 Mt. Elliott Ave.
Detroit, Mich. 48234
Robert Boyer and Philip Kemper

UNITED STATES TOBACCO COMPANY**Booth C-5**

630 Fifth Ave. New York, N. Y. 10020
M. Rothenberg, A. Saldukas, G. D. Pruitt
and S. S. Port

THE UPJOHN COMPANY**Booth C-8**

7000 Portage Rd. Kalamazoo, Mich. 49001

WALLACE LABORATORIES**Booth B-10**

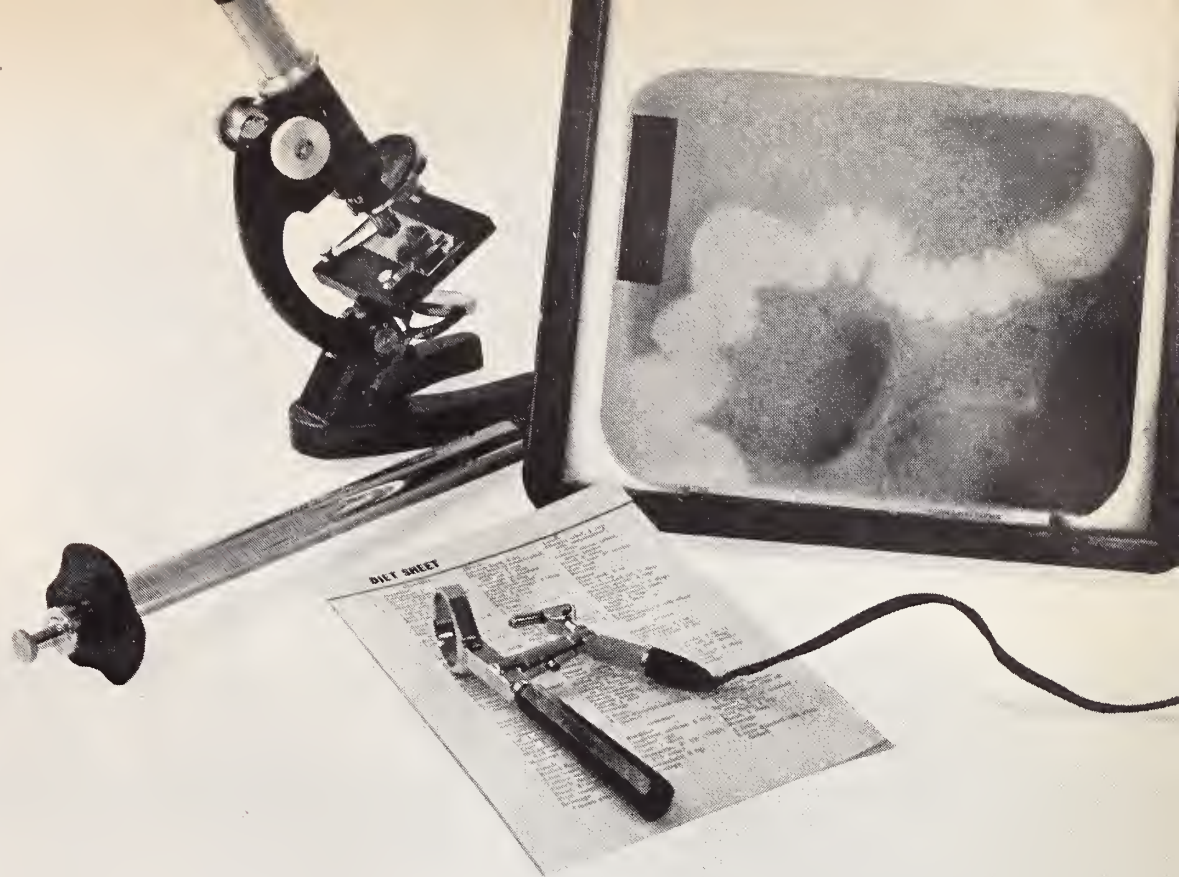
Half Acre Road Cranbury, N. J.
R. Donahue

WARNER-CHILCOTT LABORATORIES**Booth C-28**

201 Tabor Rd. Morris Plains, N. J. 07950

WINTHROP LABORATORIES**Booth B-16**

90 Park Ave. New York, N. Y. 10016
J. L. Jones, J. J. Malloy, W. K. Porter
and Moody Cross



in digestive disorders:

B and C vitamins aid therapy. Nausea, vomiting, and severe diarrhea may seriously interfere with the digestion and absorption of nutrients. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, may help meet the needs of these patients. In digestive disorders, as in many stress conditions, STRESSCAPS vitamins aid therapy.



Stresscaps[®]

Stress Formula Vitamins Lederle



Each capsule contains:

Vitamin B ₁ (as Thiamine Mononitrate)	10 mg
Vitamin B ₂ (Riboflavin)	10 mg
Vitamin B ₆ (Pyridoxine HCl)	2 mg
Vitamin B ₁₂ Crystalline	4 mcgm
Vitamin C (Ascorbic Acid)	300 mg
Niacinamide	100 mg
Calcium Pantothenate	20 mg

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

692-6-3943



Winthrop

announces

**a breakthrough in the
control of pain**

Talwin[®]
brand of
pentazocine
(as lactate)

a potent, injectable non-narcotic

**For every physician
who has ever prescribed morphine**

Talwin is the new potent non-narcotic injectable analgesic which is indicated for relief of all types and degrees of pain in acute and chronic disorders. Talwin 30 mg. is usually as effective an analgesic as morphine 10 mg. or meperidine 75 to 100 mg., but needs no narcotics controls. The duration of action of Talwin may sometimes be less than that of morphine.

A brochure incorporating analyzed information on Talwin is available. The completeness of the information will permit you to evaluate the role Talwin can play in your practice.

You can depend on Talwin to relieve pain:

WHATEVER the intensity of the pain
the cause of the pain
the site* of the pain
the duration of the pain
the chronicity of the pain
the age† of the patient

Talwin is relatively free from adverse effects of morphine, such as constipation, urinary retention, or severe respiratory depression.

It has been used, in varying dosages, in over 12,000 patients for relief of pain of medical disorders, of active labor and postoperative pain; also for preoperative or preanesthetic medication, and as an adjunct to anesthesia.

Talwin does not require a narcotics prescription

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally." (*WHO Tech. Rep. Ser.*, No. 343, 1966, p. 6.)

It is our sincere belief that the discovery of Talwin by Winthrop Laboratories will be of great value to you and your patients for whom you may have to prescribe a potent analgesic.

*Talwin should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

†Until sufficient experience is gained, it should not be administered to children under 12 years of age.

Talwin—brand of pentazocine (as lactate)

Contraindications: *Increased Intracranial Pressure, Head Injury, Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin (brand of pentazocine) should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, head-

ache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: Adults, Excluding Patients in Labor. Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg. **Patients in Labor.** A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.

Multiple dose vials of 10 ml., each 1 ml. containing Talwin (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.

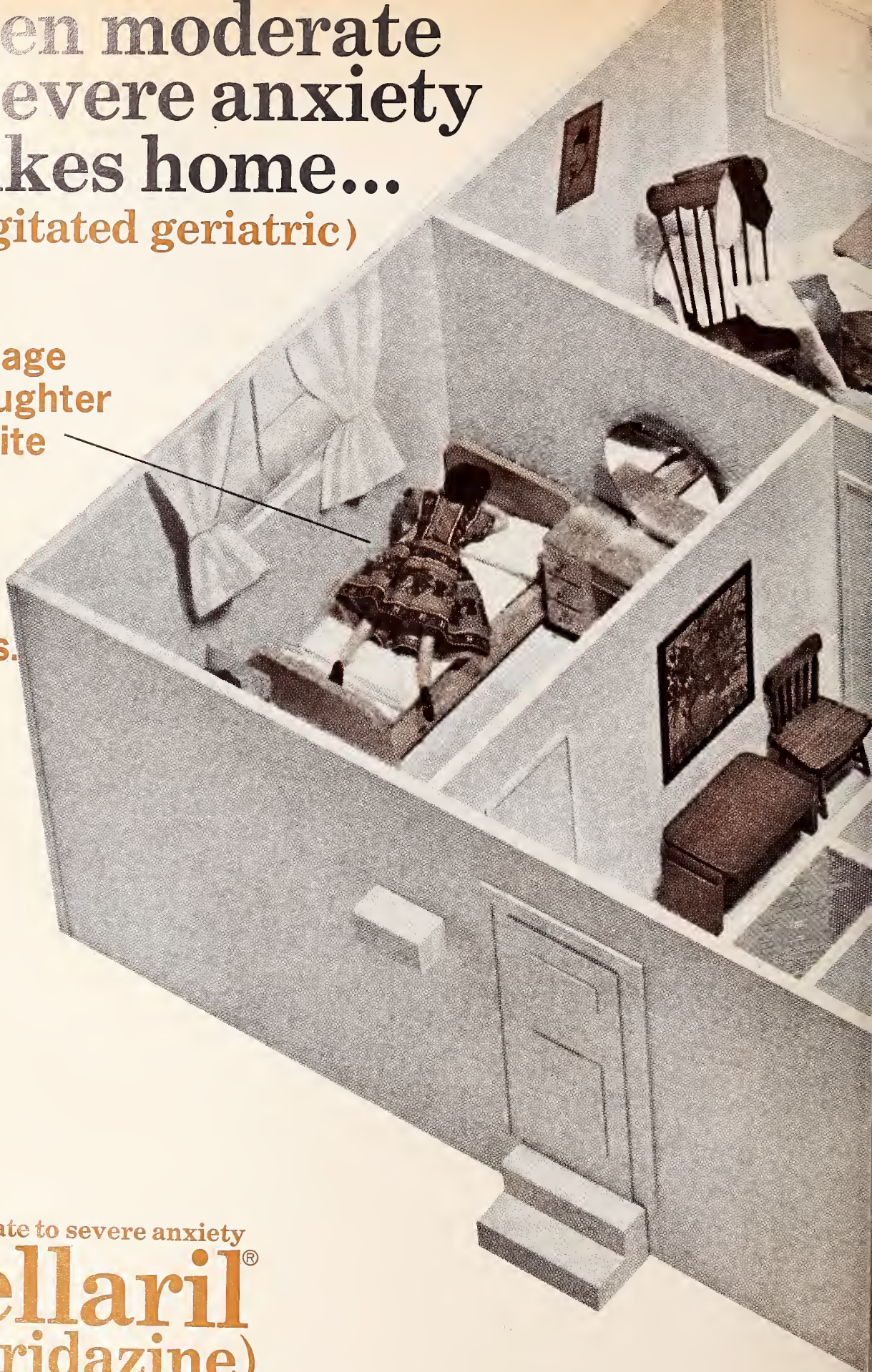


Winthrop Laboratories, New York, N. Y. 10016

When moderate to severe anxiety strikes home...

(the agitated geriatric)

His teen-age
granddaughter
won't invite
friends
home
because
of his
outbursts.



for moderate to severe anxiety

Mellaril[®]
(thioridazine)

25 mg. t.i.d.



**His slovenly room
and habits create
more tension.**

**His disturbances at
the table make every
meal a nightmare.**



**His daughter
can't please him.
There is "just no
living with him."**

See following page for prescribing information.

**When moderate to severe
anxiety strikes home...**

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide..... 195 mg.
Aminophylline..... 130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



AMA '67 HOUSTON

AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

Plan to attend this year's AMA Clinical Convention in Houston, Texas. Eighteen scientific sessions, four postgraduate courses, breakfast roundtable discussions, color television, and scientific and industrial exhibits will bring you up to date on the latest medical advances. Attend lectures by, and discussions with, our nation's outstanding medical authorities.

Between sessions, enjoy the excellent restaurants, fine shops, visitors' attractions, and mild winter temperatures Houston offers. Mail the enclosed registration and room reservation coupons now, and look forward to an exceptional convention with a holiday plus.

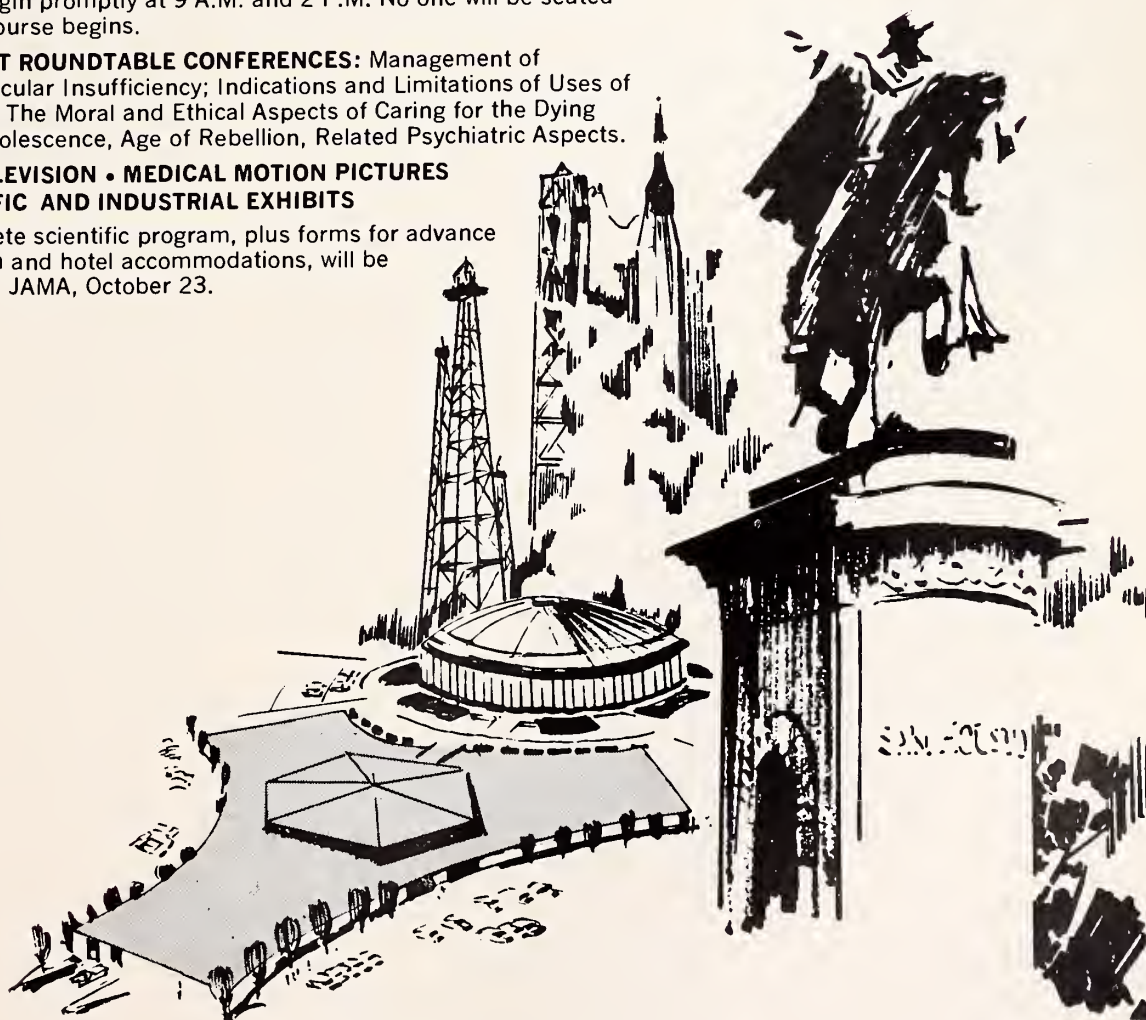
SCIENTIFIC SESSIONS: Cardiovascular Disease; Cardiovascular Surgery; New Cares; Ophthalmology; Geriatrics; Arthritis; Gastroenterology; Cancer; Antibiotics; Endocrinology; General Surgery; Dermatology; Aerospace Medicine; Obstetrics and Gynecology; Psychiatry; Pediatrics; Genitourinary Diseases; and Otolaryngology.

POSTGRADUATE COURSES: Fluid and Electrolyte Balance; Oncology; Cardiovascular Disease; and Obstetrics and Gynecology. Register for these Courses on arrival in Houston at the PG Course Registration booth adjacent to the General Registration area. There is no charge for the Courses, but registration is limited to 200 per Course. The Courses begin promptly at 9 A.M. and 2 P.M. No one will be seated after the Course begins.

BREAKFAST ROUNDTABLE CONFERENCES: Management of Cerebrovascular Insufficiency; Indications and Limitations of Uses of Antibiotics; The Moral and Ethical Aspects of Caring for the Dying Patient; Adolescence, Age of Rebellion, Related Psychiatric Aspects.

**COLOR TELEVISION • MEDICAL MOTION PICTURES
• SCIENTIFIC AND INDUSTRIAL EXHIBITS**

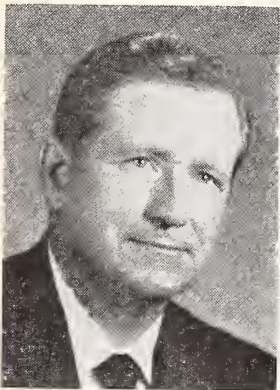
The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.



Doctor! Take the Time! Make the Effort!

OTIS R. BOWEN, M.D.
Bremen*

It isn't so. At least, it need not be so. Participation in citizenship activities in general and politics and government in particular need not cause a physician to lose patients, respect nor community standing. So many business and professional men, though they have the most to lose in a socialist takeover, are so cowed by the incessant pounding of those who want big government and socialism that they seek only to be popular with everybody and avoid becoming controversial.



They thus risk everything they ever hoped for to gain a little temporary good will which will do them no good at all if the day

of confiscation comes.

Occasionally a patient will ask, "Why do you want to get mixed up in politics?" The answer is "I'm a first class citizen interested in good government the same as you are and instead of sitting on the side lines complaining, I want to be where the action is — trying to make this community, county, state and nation a better place to raise my children and grandchildren."

Oh, it is true that perhaps an occasional hard core, politically-minded person of the opposite political faith might revolt and choose to entrust his health to someone else. But for every one of those, there is one equally as ardent on the same side of the

fence who will change to the physician in politics for his medical care. This serves to equalize.

There is no greater opportunity for service, and in spite of many abuses, no greater satisfaction than being in the mainstream of political activity and becoming more knowledgeable about government through participation. Watching the improvements of a growing community when one has a part in the planning is thrilling. A doctor should consider good government and political participation a part of his medical practice.

You Are Qualified

The main requirements for participation simply are the ability to think and make decisions; honesty and integrity; tolerance and patience; and the desire to serve. Who is then better qualified in light of these prerequisites than the doctor? His entire medical training has been in the field of diagnosis and correction of problems. This is what government is all about. Locate troubles. Find solutions. Do what is in the best interests of the majority without forgetting the rights of the minority.

Honesty and integrity should come so naturally to a conscientious physician that no further comment is needed.

Tolerance and patience are deeply ingrained in the physician to make him suitable for medical practice, but admittedly it takes a different brand of tolerance and patience in politics. Understanding politics is to know that the wheels grind slowly and that changes are brought about by tedious compromise. It is hoped that the compromise not be of principles, but pertain only to the amount and the degree of give and take. The public is

slow to understand the need for change and may at first be resistant until the facts are properly presented. I have been much impressed with the public's acceptance of necessary and good changes in the law when they have been properly presented with the facts. Presentation of the facts can best be done by one who deals with orderly planning. The physician is an expert at this. Who can deny the leadership and the influence of a physician? People recognize his education, his intelligence, his abilities and will listen to him and usually, though not always, will agree with him.

Desire, although almost always present, is too often thwarted by fear of sticking one's neck out, fear of getting involved and the fear of losing patients and income. Loss of income in many political positions — I'm in one of them — is a certainty but the loss is not fatal. Uncle Sam takes a good share of the extra one would have earned anyway. The inner feeling of satisfaction for being of service, the gratitude of some you have helped, and the reward of becoming good friends with some of the finest people on earth are more gratifying than the extra income earned by remaining totally a slave to one's profession, irrespective of how much one might enjoy it. The diversion and the secondary interest make the practice of medicine a bigger thrill.

From personal experience, patients may mildly resent an occasional absence but as long as one's temporary absence from practice is covered, they usually point with pride to the fact that their doctor is the president of the school board, the county commissioner, their state representative or their congressman.

* Speaker, Indiana House of Representatives.

Most physicians are independent in their political thinking as well as in their everyday living. They believe in individual incentive and individual initiative; they believe that government should do only those things for the people that they cannot do for themselves. They believe that a people with these qualities can and will retain their dignity.

The only pitfall that I have noted in the thinking of the physician in government is that perhaps he wants people to remain a little bit too independent in these fast times. Admittedly I felt the same way and resented almost all rules and regulations by government which tended to touch on my way of life. But through elective governmental service, through which I became more knowledgeable about the problems of local and state government, I have found that some rules are necessary. People just don't always follow the Golden Rule. If they did, very few other laws would be needed.

Problems Facing Us

Continued crowding, urbanization, transportation, communication, automation and industrialization brings about problems that we cannot solve without some orderly governmental controls and help. Some of these problems are traffic fatalities due to drink, speed and recklessness; air and water pollution due to automobile exhausts, industrial waste and human carelessness; increased crime and violence due to greed and improper respect of the rights of one another; more individual free time and increased income with too few worthwhile things to consume both. These things cannot be controlled individually; sensible governmental restrictions, regulations and controls are needed or else our health and well being will be irreparably harmed.

Now since health is so involved, just who is better qualified to help arrive at proper solutions than the physician? How better can these problems be solved than at the level

of government closest to the people? If we don't solve them at these levels, the federal government fills the void. Federal controls over many of these things have to be uniform for all 50 states, yet problems differ from one state to another so that uniform federal controls (with certain exceptions of course) do not afford the proper solution.

Decay of a community begins when its citizens turn liberty into license, responsible freedom into irresponsible indulgence, respect for the law into defiant disobedience and indignant concern into apathetic indifference.

This decay cannot exist if government is run by an intelligent, informed, moral and energetic citizenry that truly cares. Deliberate acts of greed, lust and avarice will continue unless citizens who care get involved instead of letting the other fellow do it or instead of throwing up one's hands in despair and asking "What's the use of bothering?" The unspoken creed too often is: I want to take part in civic duties and government, but don't ask me to exert myself. Likewise too many want their children to be energetic, law abiding citizens but set poor examples themselves. Such people will wake up some day to find that their freedoms are gone and that the government is truly taking over with cradle to the grave care.

Creeping Socialism

Such decay comes on gradually. Federal controls come on gradually. It is sort of anesthetizing. It's like the man who is losing his hair. It comes out so slowly that he doesn't realize it. Then one morning he awakens to find the last hair on his pillow and exclaims, "My gosh! I'm bald!"

An old legend says that you can't kill a frog by dropping it in boiling water. The frog reacts so quickly that it jumps out of the water before it can do him any harm. But, if you put the same frog in cool water and then add hot water slowly, even up to the boiling point, he won't jump out until it's too late. By the time he realizes

what has happened, he's cooked.

The story has a little humor to it but it is not a laughing matter. The moral is very plain. I don't like to see this applied to people in general and to physicians in particular. We're smarter than that; all we need to do is recognize it. It simply means that if one tried to take a man's freedom away from him overnight, one would have a revolution on his hands. But, if one takes it away a little at a time, ever so slowly, perhaps while even sweet-talking him a little, it can occur almost without protest or notice. The good citizen should act on problems with such dangers involved rather than belatedly reacting to problems and pressures after it is too late to accomplish anything except a protest because it has already happened.

Back in 1909 the federal income tax was proposed. A lot of people didn't like it. We were told that it was just a temporary measure to get us out of a short time difficulty and two-thirds of the states ratified the amendment by 1913. After all, it was only a barely noticeable one percent. But this "temporary need" is still with us and no mention of the heights to which it has mushroomed needs to be made. Other taxes have been born and risen the same way.

Many questions arise that should be considered by all, especially physicians. Will the water get hotter as Medicare and Medicaid and other programs involving us personally go on until we boil in socialized medicine? Or are we already that far? Will farm controls and market fixing all be done by Washington computers? Will Washington control education to the point of specifying what is to be taught and how, specifying classroom sizes, teacher's salaries, length of school sessions, location of schools and so on?

Capable Leadership

The doctor is truly equipped in every way to serve in capacities of governmental and political service through election and appointment and

through personal counseling service, that can help stimulate the desire of our people to retain their individual dignity. Having all decisions made for one by government is the quickest way for an individual to lose his dignity. It is gratifying to see and to know that more physicians are becoming interested and active but not really in the proportion that they are capable.

Doctors! your education, your natural leadership, the reverence with which so many people hold you should make you want to be an uncommon man — an example to the community — a leader showing how

to use opportunity and not just seeking security — one who can instill in his people the desire to seek the challenge of life instead of the guaranteed existence so as to enjoy the thrill of achievement rather than the stale calm of utopia. One doesn't lend much support to a basketball team by cheering from the living room just as one doesn't lend much corrective effort to government by griping about things that are wrong.

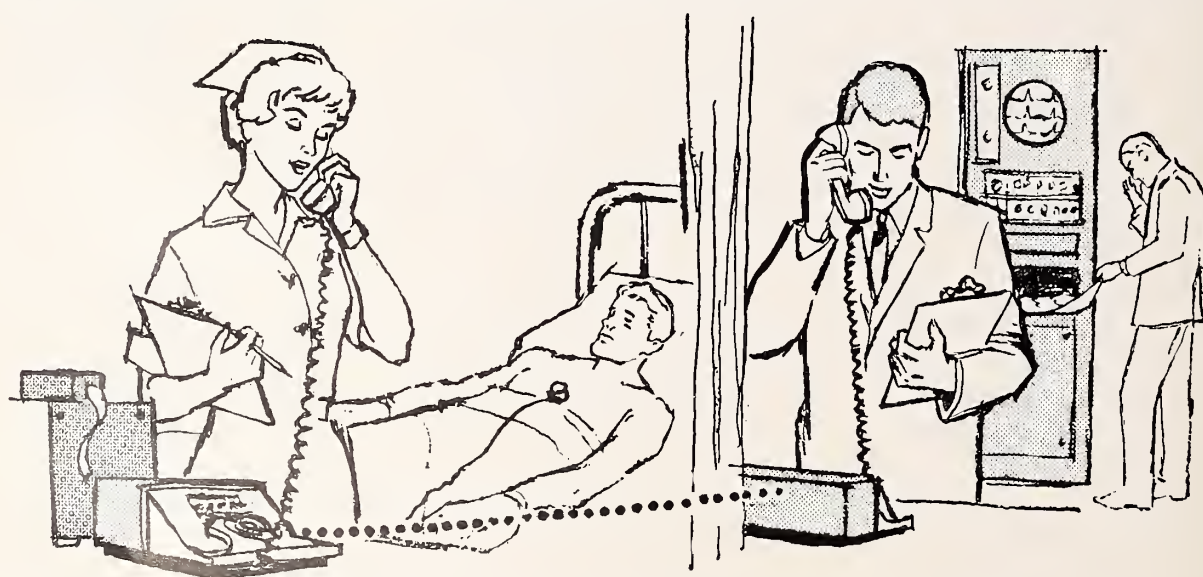
Government is necessary for law and order and in the proportion that we give government the power to do things *for* us, so we also give it the power to do things *to* us. Therefore

we must discipline ourselves and not demand the excessive, the expensive and the expansive but to the maximum extent possible we should do it ourselves.

Doctors and their wives, endowed with this philosophy, with a little more individual effort and sacrifice can enter the political and governmental arena and become leaders of people and molders of the laws, rules and regulations by which we must live.

Let's hope we are smart enough to get out of the water before we get cooked!

304 North Center St.
Bremen 46506



NOW—Practical Centralized Expert Analysis

The Bell System DATA PHONE service concept makes possible transmission of electrocardiograms, electroencephalograms and X-ray data via the regular telephone net-

work. It's fast and economical. Call your Indiana Bell Business Office about it today.



Indiana Bell

Part of the Nationwide Bell System

THEY'RE GAINING ON YOU.

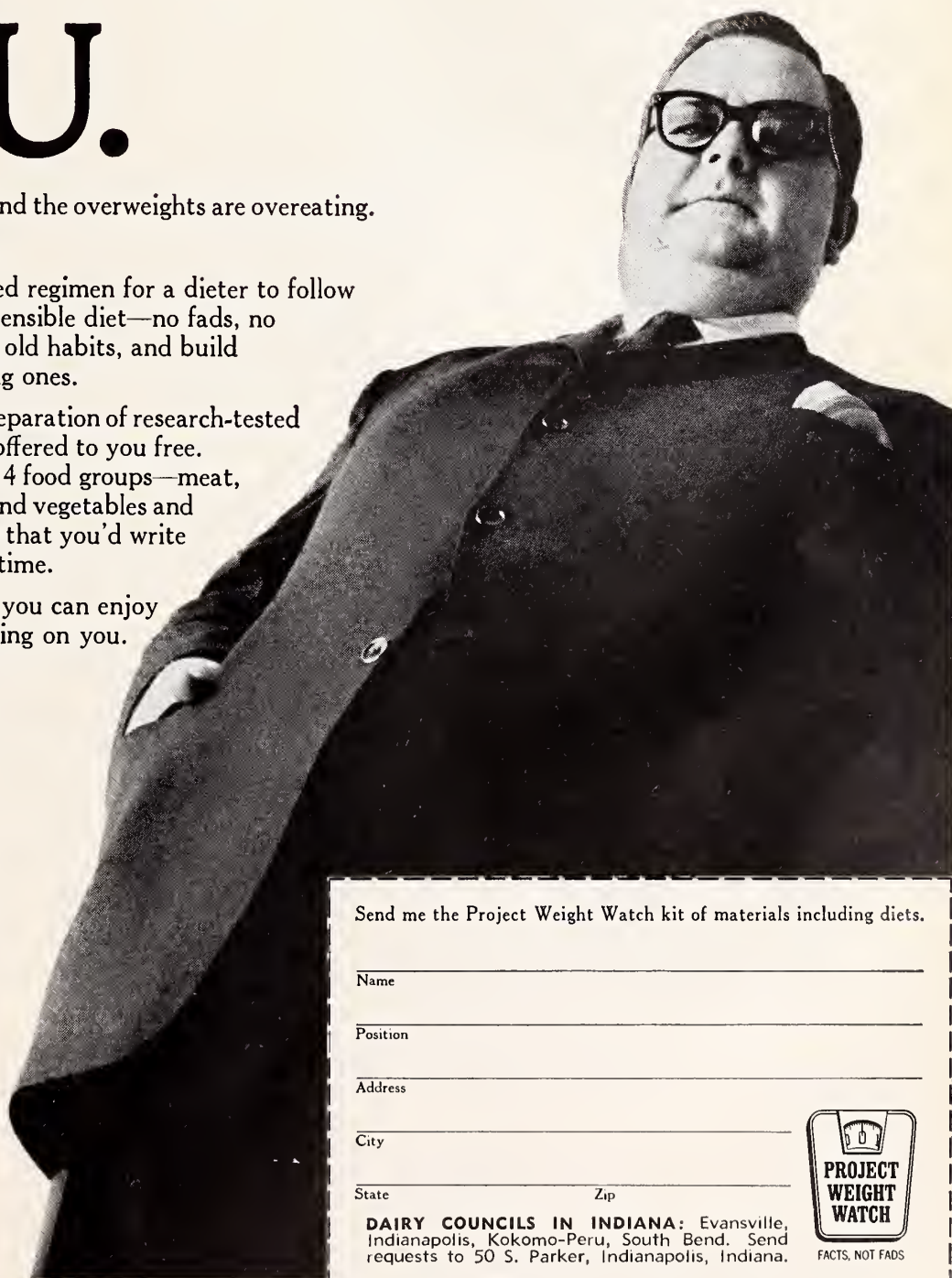
Every time you turn around the overweights are overeating.

The spread is spreading.

What's needed is a printed regimen for a dieter to follow under your guidance. A sensible diet—no fads, no fallacies—that can break old habits, and build realistic new ones. Lasting ones.

That's what prompted preparation of research-tested scientific diets which are offered to you free. They're a balance of the 4 food groups—meat, bread and cereals, fruits and vegetables and dairy foods. They're diets that you'd write yourself, if you had the time.

Send for them. After all, you can enjoy people without their growing on you.



Send me the Project Weight Watch kit of materials including diets.

Name _____

Position _____

Address _____

City _____

State _____

Zip _____

DAIRY COUNCILS IN INDIANA: Evansville, Indianapolis, Kokomo-Peru, South Bend. Send requests to 50 S. Parker, Indianapolis, Indiana.



FACTS. NOT FADS

when bursitis hits a 280-lb. tackle, hit back with **Butazolidin alka**



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcers.

or 280-lb. tackles — or 108-lb. housewives — Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

It's not for every patient. Check carefully the Contraindications, Warning and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

Play-for-pay or workaday patients — when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka — go with it.

And watch the comeback.



er and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

6509-V(B)R2

Butazolidin[®] alka

Capsules

100 mg. phenylbutazone
100 mg. dried aluminum hydroxide gel
150 mg. magnesium trisilicate
1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York



News from Indiana University School of Medicine

THE James Whitcomb Riley Hospital for Children, known throughout Indiana for its service to children, soon will have a new face.

Ground-breaking ceremonies for a new \$7.7 million addition, which will extend across the front of the present hospital, were held at the Indiana University Medical Center in Indianapolis.

The original hospital was built in 1924 with funds raised by the Riley Memorial Association in a statewide drive, a good share of it made up of nickels and dimes donated by school children. This will be the most ambitious expansion made to the hospital since that time.

Of the funds required for the present construction, nearly half (approximately \$3.5 million) will be

provided from private gift funds appropriated by the board of governors of the Riley Memorial Association. Included is a gift from the Baxter Foundation of Indianapolis of \$800,000 for a Mothers' Pavilion in the Frances D. Baxter Memorial Wing of the addition.

The rest of the cost will be covered by grants made to Indiana University by the U.S. Public Health Service for special education and health professions teaching facilities in the new building.

The ground-breaking ceremonies were held on the site of the Baxter Memorial Wing, one of three five-story wings to be built at this time. Long-range plans call for the construction of two additional wings, more than doubling the present patient capacity and providing the

most modern pediatric facilities.

The addition is designated as Phase II of the master plan for the hospital. Phase I, a \$2.5 million facility consisting of eight surgical suites of advanced design, complete pediatric radiology facilities, and a coordinated rehabilitation center, was placed in service two years ago.

In addition to the unique Mothers' Pavilion, which will afford opportunity for one or both parents of an ill child to live with him in the hospital and participate in his care, the present expansion will include a burn clinic, a diagnostic and treatment clinic for the mentally retarded, a series of new emergency treatment rooms, plus teaching facilities and additional rooms for the care of child patients. ◀

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller, Representative

665 East 61st Street Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

The AMBAR
SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

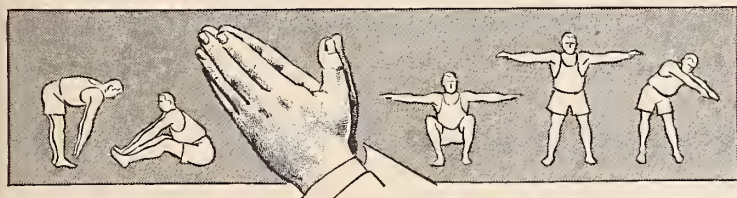


**NAPOLÉON
BONAPARTE**

**LOST THE BATTLE
OF WATERLOO BECAUSE
HE WAS TOO FAT!**

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK "PRAY YOUR WEIGHT AWAY" URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.; SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.



**DIET
DROPOUTS**

ACCORDING TO DRS. SHIPMAN AND PLESSET "APPARENTLY NO DIETER SUCCEEDS WHO IS VERY ANXIOUS OR DEPRESSED."* THE AMBAR FORMULA PROVIDES METHAMPHETAMINE TO HELP ELEVATE THE MOOD AND PHENOBARBITAL TO HELP REDUCE ANXIETY.

*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

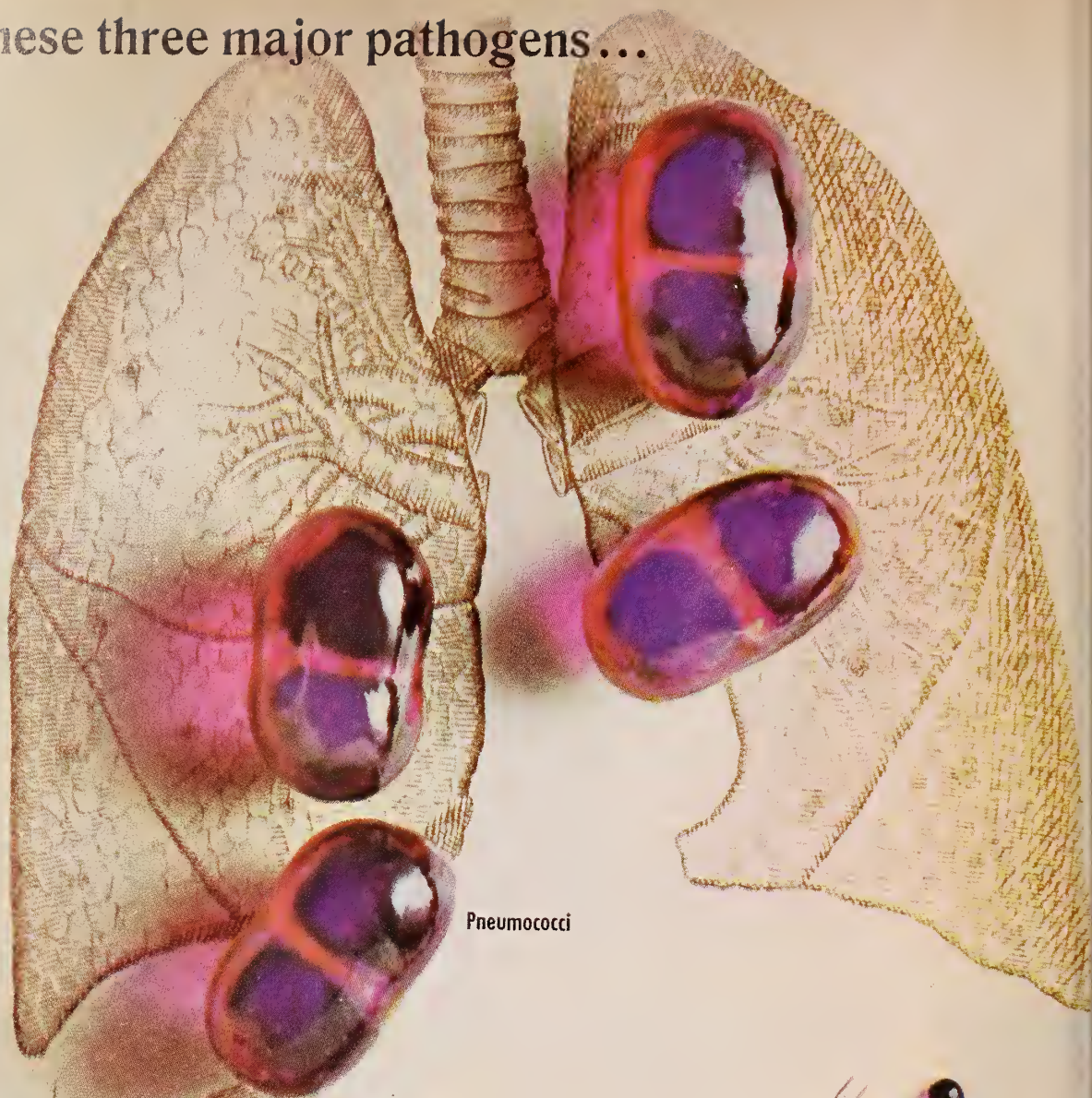
One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H-ROBINS

Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



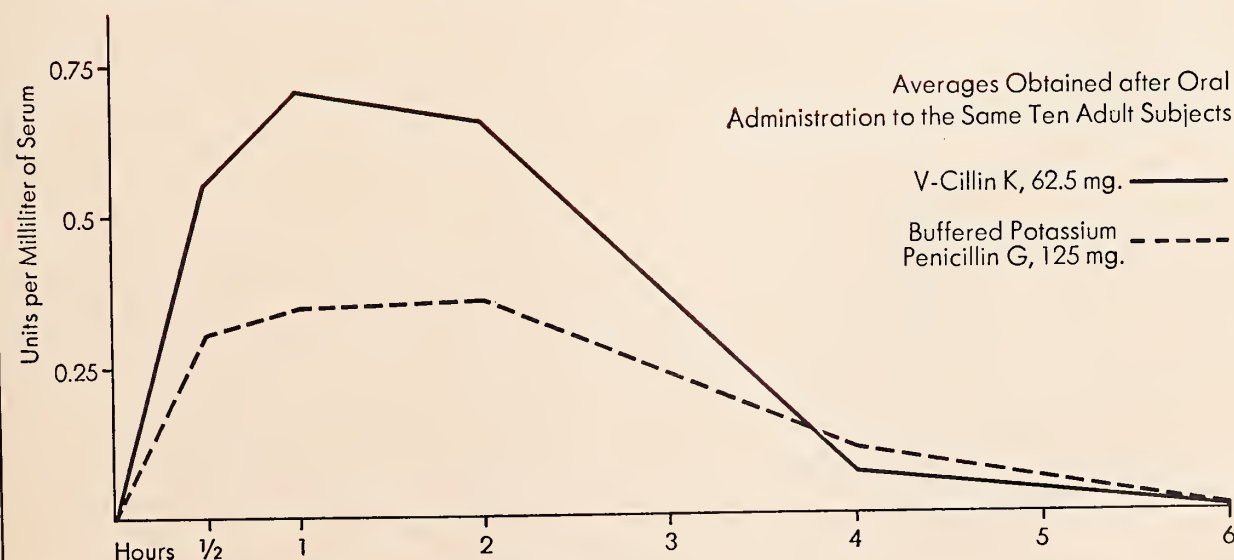
V-Cillin K[®] provides dependable oral antibacterial activity

because it combines a high degree of in-vitro activity...

Antibiotic	Staph. Aureus (Penicillin-Sensitive)		Streptococcus, Group A		Diplococcus Pneumoniae	
	MIC (mcg./ml.) Median	Range	MIC (mcg./ml.) Median	Range	MIC (mcg./ml.) Median	Range
Penicillin V	0.02	0.02-0.04	0.02	0.003-0.4	0.01	0.005-0.2
Penicillin G	0.02	0.005-1.6	0.005	0.002-0.2	0.02	0.01-0.1
Methicillin	1.6	0.4-6.3	0.2	0.1-0.4	0.2	0.1-1.6
Oxacillin	0.4	0.1-3.1	0.04	0.02-0.4	0.1	0.04-0.8
Cloxacillin	0.2	0.2-0.8	0.1	0.1-0.8	—	—
Nafcillin	0.4	0.2-0.8	0.04	0.02-0.1	0.02	0.02-0.2
Ampicillin	0.2	0.1-0.8	0.02	0.01-0.04	0.02	0.01-0.04

Adapted from Klein, J. O., and Finland, M.: New England J. Med., 269:1019, 1963.

with high blood levels, even in the presence of food



Adapted from Griffith, R. S., and Black, H. R.: Current Ther. Res., 6:253, 1964.

V-Cillin K[®]  700867
Potassium Phenoxymethyl Penicillin

(See next page for prescribing information)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxy-methyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxy-methyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with parenteral dosage schedules, frequent evaluation of the renal hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), bottles of 50 and 100; and 250 mg. (400,000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Hospital Not Entitled to Apply Overpayment on Wife's Bill to Husband's Bill — A hospital was not entitled to retain and apply to a husband's bill the portion of the money, received from two hospitalization insurers as payment for his wife's hospital expenses, that was in excess of her hospital bill, the Arkansas Supreme Court ruled.

The wife was covered by two family group hospitalization policies, one procured through her employer and the other procured through her husband's employer. Each insurer paid to the hospital, for credit to the wife's account, the amount for which it was liable to her under its policy, with the result that her account with the hospital was overpaid in a substantial amount. The hospital presented no proof that the money paid on the wife's account, under the policy procured by the husband through his employer, at any time belonged to the husband, and no proof that the overpayment belonged to the hospital. The wife was entitled to the overpayment.

Sisters of Mercy of Warren Brown Hospital v. Robertson, 41 S.W.2d 3 (Ark., Feb. 6, 1967).

Patient Denied New Trial in Suit for Allegedly Negligent Treatment of Fractured Arm — A patient was not entitled to a new trial in his suit for damages against a physician for injuries caused by his allegedly negligent treatment of the

patient's fractured left arm, where there was sufficient evidence to support the jury's verdict in favor of the physician, an Indiana intermediate appellate court ruled.

In setting the patient's arm, the physician did not fully immobilize it by using a cast, but partially immobilized it by using a metal splint and bandage covering the wrist and forearm. No bony union was achieved after six months of treatment by the physician. The patient consulted another physician who found it necessary to perform a bone graft to achieve a union. The patient now has a permanent partial disability in his arm.

The trial court erred in not submitting to the jury the issue of whether the physician was negligent in pursuing his method of treatment for six months even though the arm remained swollen, the patient continued to complain of pain, and x-rays that he had taken showed that no union had been achieved. Even without expert testimony, a layman would know that a physician should take some action of some kind in such a situation.

Negligence on the part of the patient which proximately contributes to his injury bars recovery in a suit against a physician for professional negligence. There was evidence that the patient, despite the physician's instructions that he was not to use his arm, tried to use it in lifting and carrying 50-pound sacks during the

period that he was treated by the physician. There was also the fact that the patient did not consult another physician for more than two months after discharging from the case the physician against whom this suit was brought. This negligence on the part of the patient most likely contributed to the arm's failure to heal properly.

An appellate court does not weigh the evidence and substitute its judgment for that of a jury or a trial court. Although there was no way of knowing what evidence the jury considered or what the basis of their verdict was, the verdict cannot be disturbed because there was sufficient evidence to support it. The error in refusing to submit to the jury the physician's negligence in failing to change his treatment method was not sufficient to overcome the patient's contributory negligence. The error was thus not one requiring the granting of a new trial.

Shirey v. Schlemmer, 223 N.E.2d 759 (Ind., March 2, 1967).

Suit Against Pediatrician for Failure to Make PKU Test—What is thought to be only the third medical malpractice case related to PKU and the tests for that disease was recently tried in a federal trial court in Oklahoma. It was alleged that the pediatrician's failure to make a PKU test, in the course of his treatment of the patient, delayed the diagnosis of the disease and the taking of steps necessary to prevent the patient's mental

retardation. The patient was four years old when the pediatrician treated him. The pediatrician testified that although he thought, at the time of treatment, that the patient was not normal and advised his parents to take him to an institution specializing in the problems of mental retardation, he made no PKU test because he was concerned only with treatment of the patient's serious, recurrent infections. The pediatrician admitted that he had performed the PKU on other patients. (News Release, Tulsa, Oklahoma, Feb. 2, 1967).

Physician Not Liable for Revealing Patient's Condition to Spouse — A patient was not entitled to recover damages in a suit against a physician for the injuries allegedly caused by the physician's disclosure to the patient's husband of information he obtained in the course of treating the patient, a New York trial court ruled. It was not necessary to pass on the question of whether the legislature intended, in enacting the physician-patient privilege statute, to create a cause of action against a physician who discloses information without the patient's consent or intended only to govern the admission of evidence, the court said. Since a prospective husband or wife is entitled to know whether his or her prospective spouse is suffering from a diseased condition, it followed that each had the right, during marriage, to know the existence of any disease which might have a bearing on the marital relation.

Curry v. Corn, 277 N.Y.S. 2d 470 (N.Y., June 8, 1966).

Cause of Action Stated in Patient's Suit for Injuries Following BSP Test — A trial court erred in dismissing a suit for damages against a hospital by a patient who developed thrombophlebitis following the administration of a BSP test, a Georgia intermediate appellate court ruled.

The patient, a student nurse, consulted a hospital resident about her

abdominal pains. After examining her, he ordered a BSP test. The test was administered by a hospital technician. The patient experienced pain when the fluid was injected, and her arm became swollen. She is now suffering from thrombophlebitis as the result of the extravasation of the injection fluid into the soft tissues of her arm.

The complaint sufficiently alleged the following: (1) that the technician, in administering the test, was acting as an employee of the hospital, not of the resident; (2) that the technician was not qualified to administer the test; (3) that the test was negligently administered; (4) that the patient was not given proper treatment when she complained of pain and her arm began to swell when the fluid was injected; (5) there was a causal relation between the alleged negligence and the patient's injuries.

The allegations that as the result of the patient's injuries there was the possibility that her arm might have to be amputated and that she would face grave danger if she should become pregnant were not objectionable on the ground that these were only medical possibilities. Adverse results from an allegedly tortious injury, which are probable or of which there is a substantial medical possibility, are elements of damage. Such probabilities and possibilities have caused the injured person mental pain and suffering.

Mull v. Emory University, Inc., 150 S.E.2d 276 (Ga., July 11, 1966).

Cause of Action Stated in Suit by Nurse's Aide Who Contracted Staph. Infection — A trial court erred in dismissing a suit for damages against a hospital by a nurse's aide who contracted hemolytic staphylococcus while working in the nursery for premature infants, a Georgia intermediate appellate court ruled. The nurse's aide alleged that the hospital had a duty to provide her with a safe place in which to work, that it negligently breached that duty, and

that that negligence was the proximate cause of her having contracted the infection. These allegations stated a cause of action sufficient to raise the issues of negligence, diligence, assumption of risk, and proximate cause for resolution by a jury.

Thigpen v. Executive Committee of the Baptist Convention of the State of Georgia, 152 S.E.2d 920 (Ga., Dec. 1, 1966; rehearing denied, Dec. 20, 1966; cert. denied, Feb. 9, 1967).

Clinic Not Liable for Receipt of Usurious Interest — A patient was not entitled to recover, in a suit against a medical clinic, double the amount of the allegedly usurious interest she paid to it in connection with a loan obtained to pay her bill to the clinic, the Texas Supreme Court ruled.

When the patient was unable to pay the clinic's bill, she made arrangements, at the clinic's suggestion, with a credit association and a bank for a loan to pay it. The patient gave the clinic her note for the exact amount of the bill. The clinic endorsed the note to the bank and received the exact amount of the bill from the bank. The amount of interest on the loan was paid by the patient to the clinic by a separate check. The clinic then sent its own check in the amount of the interest to the credit association. The clinic retained no part of the amount paid to it by the patient as interest.

The usury statute provides that double the amount of usurious interest paid may be recovered from the person or firm who received such interest. "Receiving" as used in the statute means "benefiting" from the interest paid. A "benefit" from the interest refers to a direct benefit from the receipt and retention of the interest itself and not to an incidental benefit such as obtaining payment of an account receivable — the only benefit received by the clinic from the transaction.

Stacks v. East Dallas Clinic, 409

Continued

“Doctor, We Understand”

To conduct your practice takes many specialized facilities and much equipment. *Expensive* facilities and equipment. We understand your requirements and, working with members of the Indiana State Medical Association, have developed a financial assistance program to meet your needs.

Funds are provided for your equipment and household needs. Also working capital to cover every professional financial need you may have in establishing or enlarging your medical practice. You don't have to use your entire fund at once, but you do maintain full control of all disbursements you make. With Merchants' P & D Plan, you get full service at rates considerably less than most available plans.

Give us a chance to prove "*We Understand*" by calling our P & D Department. The number is 638-2461, extension 370. We'll be happy to survey your request and give you our recommendations. There's no obligation.



MERCHANTS
THE BANK FOR ACTION
Indianapolis, Indiana **BANK**

S.W.2d 842 (Tex., Nov. 2, 1966; rehearing denied, Jan. 18, 1967).

Patient Gets New Trial in Suit for Physician's Failure to Inform of Risks of Stapedectomy — A trial court erred in directing a verdict in favor of a physician, in a suit for damages against him by a patient who suffered a complete loss of hearing in his left ear following the physician's performance of a stapedectomy. The patient proved the medically accepted standard for informing a patient of the risks of the operation by expert medical testimony, the Texas Supreme Court ruled.

The physician recommended a stapedectomy with vein graft to correct the impairment of hearing in the patient's left ear. The patient testified that when he asked about the risks of the operation, the physician told him that 90% of them were successful, that there was a 10% possibility that his hearing would not be improved or could be worse after the operation, and that his sense of taste might be altered. He also stated that the physician led him to believe that he had previously performed the operation, although this was the first stapedectomy that he had performed. The patient testified that he had experienced vertigo, instability, tinnitus, and total loss of hearing in his left ear since the operation and that he had not been warned of any of those risks.

In a suit against a physician for having failed to disclose the risks incident to the surgery or treatment, the patient has the burden of proving, by expert medical evidence, what a reasonable medical practitioner of the same school and the same or a similar community would, under the same or similar circumstances, have disclosed to the patient about the risks incident to the proposed treatment or surgery, that the physician departed from that standard, and that injury resulted to the patient. The physician's testimony

that he agreed with a statement in a textbook that although patients should not be discouraged from assuming the risks of a stapedectomy, they should be made aware of them, did not establish the medical standard as to the disclosure required in connection with a stapedectomy. There was no expert testimony that standard medical practice required the surgeon to disclose to the patient his experience with respect to the particular operation. The physician testified that it was standard medical practice to inform a stapedectomy patient of the possibility of vertigo, instability, and tinnitus, because they were only temporary effects of the operation. The physician also testified that it was standard practice to inform a stapedectomy patient that 90% of the operations were successful, that there was a 10% possibility that there would be no improvement in hearing, and that there was a total loss of hearing in one percent of the cases. That testimony was sufficient to establish the standard of medical care by which the physician's conduct was to be judged. The physician testified that he told the patient all of those facts. The patient testified that the physician told him nothing about the possibility of a total loss of hearing. This conflict in the testimony as to the warning of the possibility of a total loss of hearing raised a question of fact for the jury.

There was no abuse of discretion in the trial court's refusal to permit a physician, who was no longer in practice, but was engaged in business, to testify as an expert witness for the patient. He had no special knowledge of the diseases and treatment of the ear, and was unfamiliar with stapedectomies or accepted medical standards for warning patients of the risks thereof.

Wilson v. Scott, 412 S.W.2d 299 (Tex., Feb. 1, 1967).

\$1,500,000 Damages Awarded Patient Who Contracted Encephalitis After Surgery — In a suit

against two physicians and a hospital, a patient who contracted encephalitis after a hemorrhoidectomy and a spot ligation of varicose veins was awarded damages of \$1,500,000 by a Florida trial court jury. The patient went into a coma two days after the operation and has been paralyzed from the neck down ever since. (News Release, Miami, Florida, April 23, 1967).

Physician Recovers in Suit for Fees; Patient's Malpractice Counterclaim Dismissed — A trial court's judgment in favor of a physician, in his suit against a patient for his fee for performing abdominal surgery on her, and dismissing the patient's counterclaim for damages for injuries caused by his alleged negligence was affirmed by a Louisiana intermediate appellate court.

The patient alleged that because of her long history of pain, she had submitted to the operation only after the physician agreed that he would administer nothing more than morphine and Dramamine postoperatively. She further alleged that he breached the agreement by prescribing tranquilizers and Darvon postoperatively, and that his postoperative treatment was not in accordance with accepted standards of practice. At the trial, she testified that there was no agreement as to the administration of morphine and Dramamine, but that the physician had agreed that Compazine would not be administered postoperatively. There was no evidence that Compazine was ever administered to the patient. The patient's claim that the physician exceeded the limits of her consent was completely without merit, the court said. Equally devoid of merit was her claim that the physician was negligent in his performance of the operation and in his postoperative treatment of her. There was not a scrap of evidence suggesting negligence on the physician's part.

Aiken v. Kimbrell, 196 So.2d 281 (La., March 6, 1967).

Professional Life's

NEW! PARTICIPATING WHOLE LIFE INSURANCE

*We Invite You
To Compare...*

- LOW GROSS PREMIUMS
- HIGH EARLY CASH VALUES
- ATTRACTIVE POLICY DIVIDENDS

A ledger statement illustration tailored to your specific age, which is available on your request, will quickly identify the benefits and values of Professional Life's New Participating Whole Life Insurance.

We welcome your comparison of the high values and the low net costs with rates available from any other life insurance company.

ILLUSTRATION OF PREMIUMS AND POLICY VALUES
PER \$1,000 OF INSURANCE

Age at Issue	Annual Premium	20th Year Policy Values	
		Accumulated Cash Value	Accumulated Dividends*
24	\$12.90	\$261.59	\$ 63.53
25	13.30	269.31	65.79
26	13.75	277.16	68.98
27	14.20	285.14	72.27
28	14.65	293.24	75.78
36	19.45	361.30	107.90
37	20.20	370.12	112.51
38	21.00	378.99	117.07
39	21.80	387.92	121.77
40	22.65	396.90	126.55
41	23.60	405.91	131.45
42	24.55	424.02	141.43
54	40.95	516.77	222.19
55	42.90	524.54	230.31
56	44.95	532.38	238.53
57	47.10	540.25	246.76

*Dividend illustrations included above are based on present scale and are neither guarantees nor estimates for future years.

**MINIMUM
ISSUE
\$10,000**



*Professional Life
& Casualty Company*

HOME OFFICE: 720 N. Michigan Ave.,
Chicago, Ill. 60611

EDWIN S. HAMILTON, M.D., Chairman
EDWARD L. COMPERE, M.D., President
NORMAN R. B. KING, General Manager

**WRITE
TODAY**

A "ledger statement illustration" tailored to your specific age is available upon request, without obligation. Just fill out the attached coupon and mail today.

PLEASE SEND ME A "LEDGER STATEMENT ILLUSTRATION" TAILORED TO MY AGE, WITHOUT ANY OBLIGATION ON MY PART.

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____
867 IN Month Day Year



Optimil®

THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.¹⁻⁵

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.⁶ (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.⁷⁻⁹

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: *ibid.* 9. Nichols, M.: *ibid.*



Optimil, the first optimum-nutrition infant formula

from a world leader in nutritional research... **Carnation®**

**WANTED: Locations
Physicians**

GENERAL PRACTICE

Jose R. Ramirez, 20206 Butternut Lane,
Warrensville Heights, Ohio 44122—with
surgery
A. M. Koyani, Jacksonville State Hospital,
Jacksonville, Ill. 62650
Behzat Sarihan, 808 Cedar Lane, Knox-
ville, Tenn. 37912

SPECIALISTS

Bulent A. Ozsezen, Southeast Florida Tu-
berculosis Hospital, P. O. Box 3084,
Lantana, Fla. 33460—*Anesthesiology*
Harold J. Richards, 1912 Whitehall Dr.,
Winter Park, Fla., 32798—*Dermatology*
—available July, 1968
Jalaloddin Afnan-Badree, 2 Fowler Ave.,
Apt. 124, Lynbrook, Long Island, New
York 11563—*Ear, Nose and Throat*
Feliciano F. Jimenez, 1312 W. Argyle St.,
Chicago, Ill. 60640—*Internal Medicine*
Andrew Edes, 3101 N. 46 Place, Phoenix,
Ariz. 85018—*Neurology*
Sidney S. Davenport, State Univ. of Iowa,
Iowa City, Iowa 52241—*Neurology*—
available 8/68
Oscar U. Fernando, 23467 Plumbrooke
Drive, Southfield, Michigan 48075—
Neurosurgery—available 7/68
Juan M. Chavez, 730 Ashburton, Baltimore,
Md. 21200—*OBG*—available 7/68
Jack Wolper, 2800 S. Ellis Ave., Chicago,
Ill. 60616—*Ophthalmology*
Farouq A. Al-Khalidi, 407 Hawkins Road
E., Selden, New York 11784—*Ortho-
pedics*

Tun Win, Mercy Hospital, 2221 Madison
Ave., Toledo, Ohio 43624—*Pathology*
Lewis E. Nolan, P. O. Box 68, Tomah,
Wis. 54660—*Pathology*
Gloria H. Mortera, V. A. Hospital, Lin-
coln, Neb. 68501—*Pediatrics*
Abran E. Handy, 1460 Burlington Rd.,
Cleveland Heights, Ohio 44118—*Radiol-
ogy*
Giles R. Locke, 10 Vaughn Court, Eaton-
town, New Jersey 07703—*Radiology*—
available 7/68
Benito C. Liu, 4414 N. Paulina St., Chi-
cago, Ill. 60640—*General Surgery*
Agustin K. Barrido, 2520 S. Parkway,
Chicago, Ill. 60616—*Urology*
George N. Shadle, 11 Glen Ridge Lane,
Pittsburgh, Penn. 15243—*Pharmaceuti-
cal Industry*
Agustin M. Ruiz, V. A. Center, Wadsworth,
Kans. 66089—*Radiology*

ADDITIONAL LOCATIONS

County	Town
Marion	INDIANAPOLIS—population 480,000. Opening for general practitioners on the southwest side of Indianapolis. One semi-retired physician in area. Six hospitals located in Indianapolis. Most of the income in this area comes from the numerous heavy industries located in the Indianapolis area. Office available. Businessmen of area willing to assist in getting physicians established. Contact Mr. Joseph E. Wood, Jr., 1737 Howard St., Indianapolis 46221. Telephone 637- 7125.

Miami—PERU—population 15,000 located
in north central Indiana close to the
new Mississinewa Reservoir soon to be
opened. Several small to moderate sized
industrial firms in the town. There is
an 80-bed hospital with plans for expan-
sion soon. Only four general practitioners
who are actively practicing. Professional
committee willing to assist in all areas
in establishing a practice. Contact Lloyd
L. Hill, M.D., Chairman, Professional
Committee, Peru Chamber of Commerce,
Peru. Telephone 473-6653.
Porter—CHESTERTON—population 4,500.
Community is growing rapidly, located
five miles from Bethlehem Steel and
Midwest Steel mills. A 230-bed hospi-
tal located at Valparaiso. Need for
general practitioner. Contact William
Robertson, M.D., 600 E. Morgan Ave.,
Chesterton. Telephone 219-926-1721.
St. Joseph—SOUTH BEND and surround-
ing area. Population of South Bend is
133,000. Located in the northern part of
Indiana. Home of Notre Dame Univer-
sity. Three hospitals. Dire need of both
general practitioners and all medical
specialties on a private practice basis.
Contact Harry C. Davis, Ex. Secretary,
St. Joseph County Medical Society, 106
W. Monroe St., South Bend 46601. Tele-
phone 288-4401.
Washington—SALEM—County seat town
with a population of 4,600. A 60-bed
county hospital. Located in the south-
eastern part of Indiana. Seven physicians
in the county. Contact A. R. Episcopo,
M.D., Salem, Indiana 47167, for further
details. ◀

INDIANA BRACE, INC.

CERTIFIED ORTHOTISTS & FACILITY

ORTHOPEDIC BRACES — SHOES — APPLIANCES

1815 N. Capitol Ave.
Capitol Professional Bldg.
Indianapolis, Ind. 46205
Suite G01-G05
Phone 923-2351

•

16 N. Earl Ave.
Lafayette, Ind. 47904
(Phone 447-9137)

ew drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

he reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

his reliable action provides prompt relief of constipation. It also makes Dulcolax par-

ticularly useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. **Side Effects:** As with any laxative, abdominal cramps are occasionally noted, particularly in

severely constipated persons. High dosage may result in loose, unformed stools. **Contraindication:** Contraindicated only in acute surgical abdomen. **Availability:** Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.



You may be prescribing **Hygroton[®]**, chlorthalidone

You usually prescribe one tablet daily, but every once in a while you like to cut the dosage. So instead of giving the 100 mg. tablet every other day or breaking it in half, why not prescribe the new half-strength tablet every day?

See next page for a brief precautionary statement.

but you
don't know the
half of it.

**New HYgroton
50 mg.**

For a clinical supply,
please mail us this coupon
with one of your
prescription blanks.



Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Broad scope diuretic

Hygroton
chlorthalidone

Hygroton is indicated in certain conditions where the newer nonthiazide diuretics are not recommended, e.g. hypertension, edema of pregnancy, premenstrual edema, edema in obesity states, steroid edema.

However, the newer diuretics are probably superior to Hygroton in acute pulmonary edema and the nephrotic syndrome or any condition where the glomerular filtration rate is significantly low.

Geigy

Indications

Hypertension

Such as hypertension with or without congestive failure, where Hygroton can be used alone or in conjunction with other agents

(*Precaution:* Antihypertensive therapy with Hygroton should always be initiated cautiously in post-sympathectomy patients and in patients receiving ganglionic blocking agents or other potent anti-hypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension.)

Edema

Such as edema associated with: congestive heart failure or renal disease

(*Precaution:* Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises.)

or hepatic cirrhosis

(Hypoproteinemia, if present, must be corrected concomitantly.)

(*Precaution:* Take special care: discontinue if liver dysfunction is aggravated, since hepatic coma may be precipitated.)

or steroid administration

or obesity

or the premenstrual syndrome

or pregnancy, including toxemia

(*Warning:* Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult, e.g. thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc., are potential problems in the newborn.)

Contraindications

Severe Renal or Hepatic Disease and Demonstrated Hypersensitivity

Other general warnings, precautions and adverse reactions

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Precautions: Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and

potassium supplements given, provided the patient does not have marked oliguria.

Take special care in severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, dysuria, impotence, transient myopia, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50-100 mg. with breakfast daily.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg. in bottles of 100 and 1000.

Please see full Prescribing Information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

MAKE YOUR ROOM RESERVATIONS NOW!

for the 118th

Annual Convention of the

Indiana State Medical Association

House of Delegates opening session

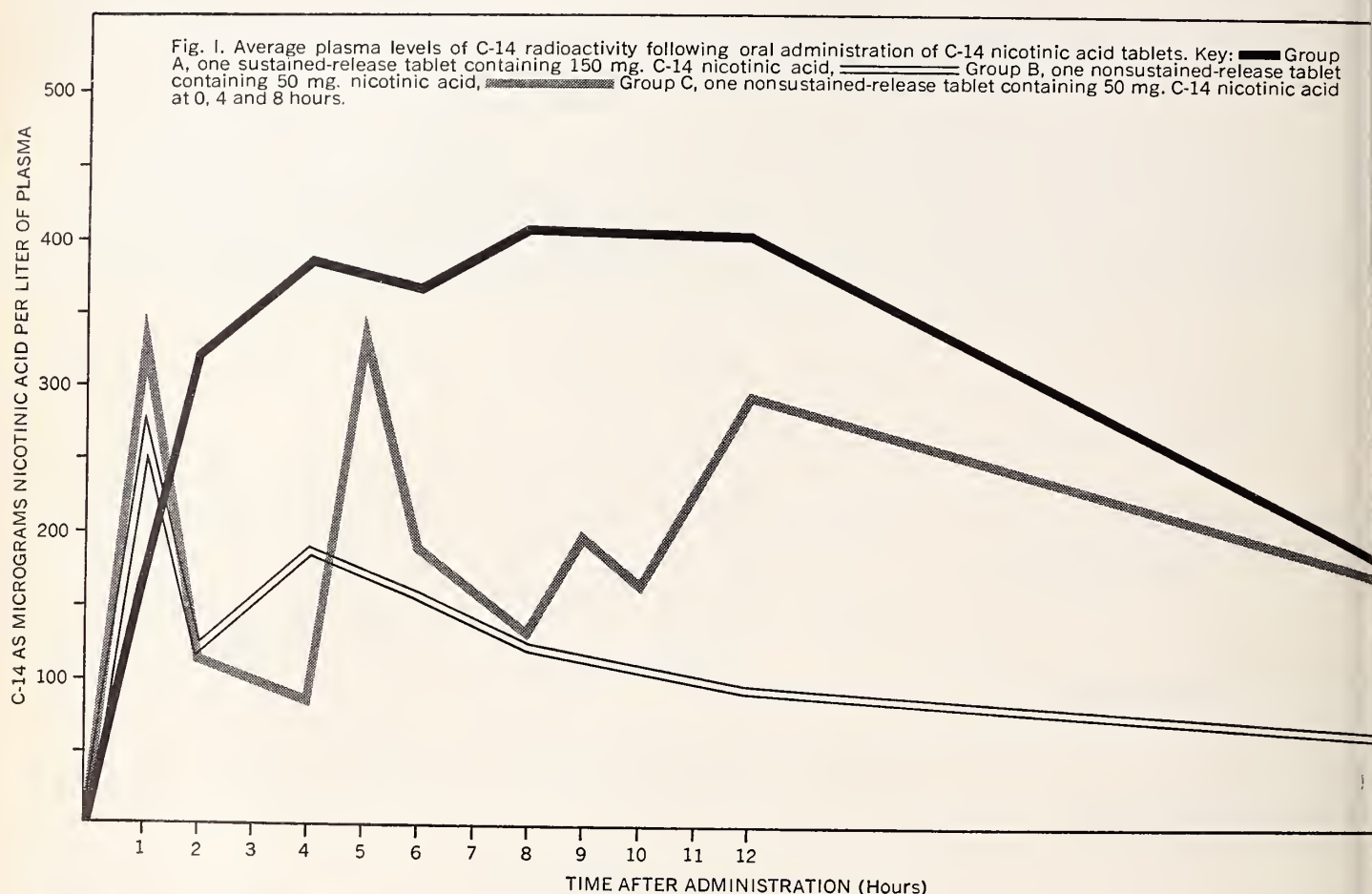
2:00 p.m., Monday, October 9, 1967

	Single	Double and Twins	Suites
lers Hotel 50 N. Meridian	6.50 - 10.00	11.00 - 13.00	
ypool Hotel 4 N. Illinois	8.50 - 12.00	14.00 - 18.00	35.00 - 50.00
raton-Lincoln 17 W. Washington	8.50 - 11.85	14.85 - 15.85	32.00 - 52.00
rott Hotel 625 N. Meridian	9.00 - 15.00	13.00 - 18.00	30.00 - 50.00
uffer Inn 820 N. Meridian	12.00 - 20.00	16.00 - 26.00	26.00 - 40.00
oliday Inn 500 W. Washington	11.00 - 12.00	15.00 - 16.00	20.00, 25.00
oliday Inn 920 N. Meridian	11.00	12.00	20.00
ward Johnson's 501 W. Washington	11.00 - 18.00	12.50 - 16.00	20.00, 25.00

ates subject to change

YOU ARE ADVISED TO REQUEST RESERVATIONS
EARLY TO ASSURE YOU OF YOUR CHOICE OF
HOTEL AND ACCOMODATIONS

Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

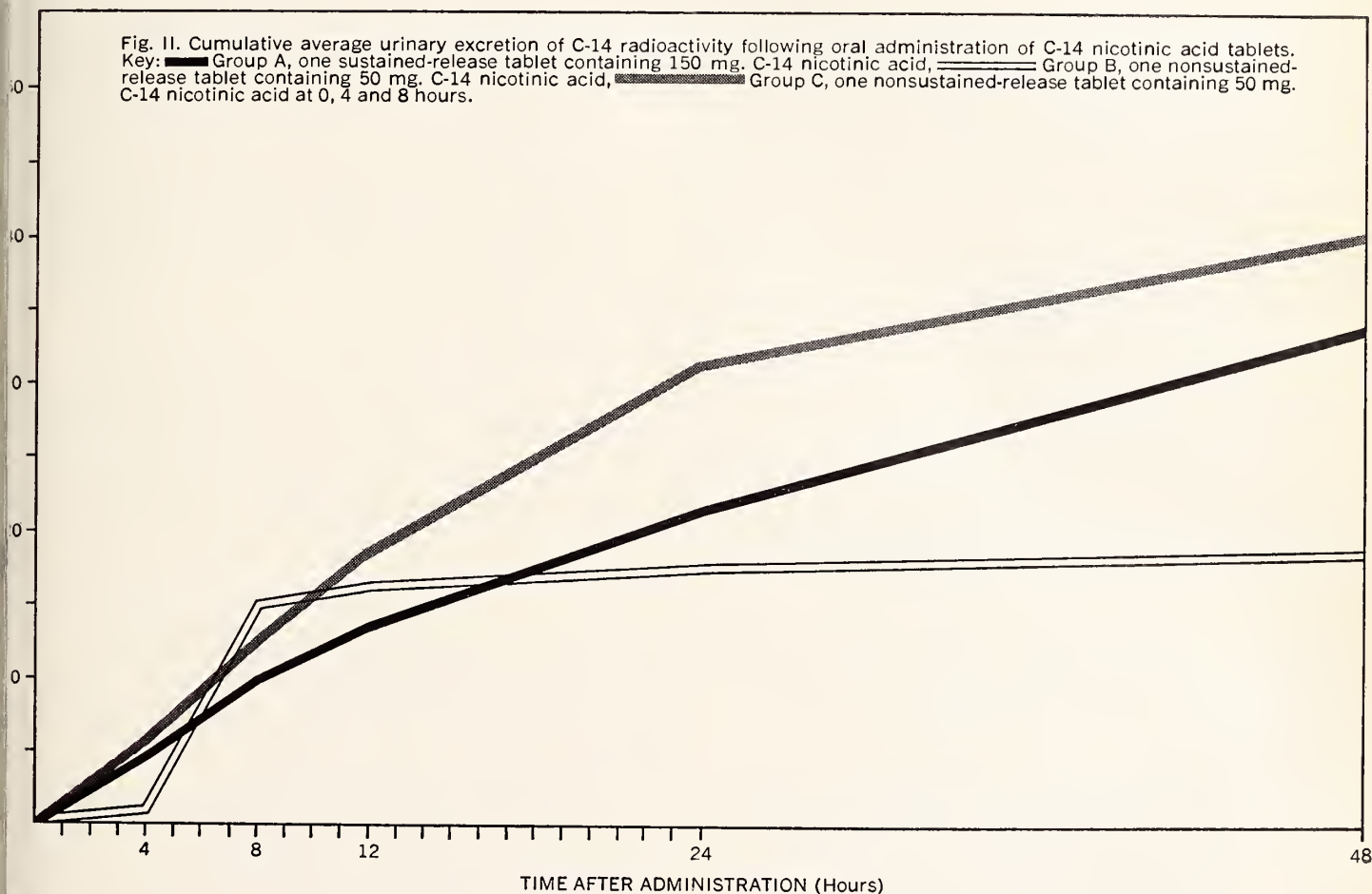
mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilation needed in patients with deficient circulation with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylentetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate signs of senile confusion. Patients become more alert

ed and debilitated

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: — Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, — Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, — Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, lethargy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-extended nicotinic acid/pentylentetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.

"First with the Retro-Steroids"

PHILIPS ROXANE LABORATORIES

Division of Philips Roxane, Inc., Columbus, Ohio

A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol[®] TT

nicotinic acid 150 mg., pentylentetrazol 300 mg.

Tempotrol[®] Time Controlled Tablet

ABSTRACTS

BOOK REVIEWS

THE GENE: A CRITICAL HISTORY

Elof Axel Carlson, W. B. Saunders & Co., Philadelphia, 1966; 301 pages; illustrated; \$9.00.

Dr. Carlson studied under the distinguished pioneer of gene studies, Prof. Hermann J. Mueller. In this present study, he correlates the history of the development of the subject, presenting the already known and very succinctly presents the problems of the immediate future in which he will be participating most actively.

The detailed historical analysis most of us can gloss over. As Dr. Carlson himself says "An illusion of progress forms a pattern of history"—just who is reduced to obscurity and who is elevated to near sanctity is really irrelevant.

I can recommend most highly the concluding chapter in which Dr. Carlson presents compactly his sophisticated view of the gene concept. Just what is the cistron? And the operon? Gene size and function are being measured in Angstrom units at precise chromosomal sites.

The molecular phase of genetics is already being visualized. The precise steric formulae of chromosomal division and replication will be written before the close of the present century. Dr. Carlson will be among those achieving this goal; I envy him.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

PATHOLOGY

W. A. D. Anderson and 38 collaborators, The C. V. Mosby Co., St. Louis, 1966; 1460 pages and 1260 illustrations plus several plates; fifth edition; \$21.00.

As the quality and format of the succeeding editions continue to improve, "Anderson" has become a very accepted, standard reference volume on pathology. By dint of rigorous pruning, the editor has been successful in giving not only pathology as such but also much of what is usually reserved for the textbook on medicine.

The readability of the chapters is somewhat uneven. Because of the condensations, there is more often than not a tenuous, staccato style, demanding close attention to every printed word. I did like particularly the very good chapter on leprosy. It is an excellent resume even if no mention is made of the fact that BCG can convert the negative lepromin test into being positive. Also, I was amazed to see how much Dr. Richter could squeeze into the chapter devoted to "Blood and Bone Marrow." In a mere 40-odd pages he just about "covers the waterfront." Of course, the beautiful color plate is a big assist.

And speaking of color plates: how about more in future editions? We know these are very expensive but—? ?

The printing and binding are excellent. Typographical errors are few and do not detract. Thus, (on p. 359), "obviously" is recognizable even if a couple of letters have been reversed. The price is within reason. Altogether, a very worthy updating of a splendid work! !

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs
for a few days health vacation
—the mineral baths and excellent
meals in an atmosphere of
serenity will leave your cares
behind and play golf on a
beautiful course.



HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate
Medical Director

OSLER'S TEXTBOOK REVISITED

Reprint of selected sections with commentaries, edited by McGee Harvey and Victor McKusick, Appleton, Century, Co., New York City, 1967; paperback; 361 pages.

Seldom have I anticipated the appearance of a book more timely; I do not recall having experienced so total a disappointment. Selected sections of the 1909 edition have been reproduced. Numerous contemporary luminaries have commented on the changes that have occurred in the intervening 60 years: just what was awry with my expectations?

Well! I am old enough to have all but memorized (a much later edition) Osler as a medical student and Cook County Hospital (Chicago, Ill.) resident. The last World War II Christmas rewrite of Osler is still on my shelf, sitting beside the late editions of Cecil, Harrison, Price et al. But: what did I really expect?

When one visits the Cheops Pyramid, the sight of a Bunker-aster geodesic would be incongruous. A glittering steel and glass skyscraper would NOT grace Angkor-Vat. Can anyone possibly "revise" and bring up to date William Harvey's "motu et vis"? Mayhap, it is a measure of the vast forward leap of 20th century medicine that I write as I do. Let us leave Osler's matchless erudition and sonorous prose to the ages. Commentary just distasteful by gilding the lily!

Get the original: a first edition if you are that lucky! I have to find a copy.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

CH, HEAT AND PAIN

Foundation Symposium edited by A.V.S. De Reuck and Knight, Little, Brown and Co., Boston, Mass., 1966; 389 with numerous illustrations and tables; \$14.00.

is still another way-station on the road towards accumulating (and correlating) basic knowledge as to our anatomic make-up and its application to an understanding of our physiology and its logical aberrations.

ing full use of such modalities as electron microscopy, meters and computer technics, we come up with an increasing analysis of the minute anatomy of sensory systems embracing Reissner and Herbst corpuscles as well as the naked nerve endings—the neural pathways transmitting the evoked sensations and their transformations into consciously accepted stimuli,

initial neural encoding stimulus characteristics are dissected mentally; these are converged at central relays, then, their cortical level expression are looked at. We still do not possess facts which would enable us to give the biochemical formula that will (some day) tell us just what is occurring on the molecular level.

is strictly for the specialists talking to their peers. The ideal practitioner—such as you and I—derive but little benefit from the volume. As usual, the printing is excellent, typographical errors are all but non-existent and the format is first. In another decade or two, a new structure of practical knowledge will be raised on this foundation.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

IAL EXPERIENCE WITH ODED TWO-WAY MEDICAL TELEVISION

R. Smart, T. H. Sternberg, and A. A. Clinco (Univ. of California School of Medicine, Los Angeles)

J. Med. Educ. 41:977-981, (Oct.), 1966.

oded television for postgraduate medical education encompasses most of the advantages of closed-circuit television, as well as cheap, potentially wide coverage of open circuit television. Making the community hospital the reception center for these programs and by providing for live feedback from the audience, community hospitals become a branch of the "university with walls" in the lifelong education of physicians. By means of newly developed, cheap home videotape recorders, it is now possible for the hospital staff to record these television programs and broadcast and then replay them at whatever hour and as many times as they desire. It also allows the network to duplicate programs and mail them to hospitals outside the range of the direct broadcast system. This means that the practitioner may have an excellent, up-to-date program at any time.

CHARACTERISTICS AND EPIDEMIOLAE OF PAREGORIC ABUSE

M. Lerner (Wayne State Univ. School of Medicine, Detroit)
J. Oerther

Ann. Intern. Med. 65:1019-1030, (Nov.), 1966.

Paregoric addiction has been reviewed during its unusual pre-

valence in Detroit (1956-1965). It recruited many young people to its lists, and once the habit was acquired, it was extremely difficult to break. These users did not hold responsible jobs, but were not prone to crime as had been noted with heroin addicts. Paregoric addicts, as a singular distinction from other narcotic users, prefer the jugular vein. They are also particularly prone to infection. Virus hepatitis, septicemias, bacterial endocarditis, and abscesses at injection sites were most frequent. Pulmonary hypertension due to talc granulomata of the lung (associated with the concomitant infusion of tripeleminamine hydrochloride) and multiple venous sclerosis were also observed. This practice has been abruptly curtailed here by making all paregoric usage by prescription only.

NEW DRUGS: 1967 — A REVIEW

1967 edition evaluated by AMA Council on Drugs, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610, 1967; 590 pages; \$3.50.

The physician must have readily available sources of balanced, authoritative information in order to cope effectively with the complexities of modern pharmacotherapy. *New Drugs*, a publication of the AMA Council on Drugs, now in its third edition, provides such information on new drugs.

The 1967 edition of *New Drugs* is a compilation of introductory statements on various therapeutic classes of drugs and monographs on single-entity drugs marketed in the United States during the period 1957-1966. It contains 265 individual drug monographs, each of which gives information on the actions and uses of the drug and its adverse reactions, contraindications or precautions,

KIDNEY FOUNDATION OF ILLINOIS

3RD ANNUAL SYMPOSIUM ON CLINICAL ADVANCES IN KIDNEY DISEASES

Sheraton-Chicago Hotel

Wednesday, October 11, 1967

Guest speakers will include:

Dr. Harriet Dustan, Cleveland Clinic; **Dr. Charles Klee-man**, Cedars-Sinai Medical Center, Los Angeles; **Dr. Robert L. Vernier**, University of California at Los Angeles; **Dr. Lowell King**, Children's Memorial Hospital, Chicago; and **Dr. Willem J. Kolff**, University of Utah Medical School.

Topics will include:

Clinical Pharmacology of Diuretics
Approach to the Patient with Kidney Stones
Congenital Disorders of the Genitourinary Tract
Chronic Dialysis and Renal Transplantation
Evaluation of the Patient with Hypertension
Drug Therapy of Renal Diseases
Conservative Management of Chronic Renal Failure

Registration Fee: \$15.00, including luncheon. \$6.00 for students, interns, residents. Send registrations to Kidney Foundation of Illinois, 127 N. Dearborn St., Chicago, Ill. 60602.

dosages and routes of administration, and sizes and strengths of available preparations. The introductory statements to 21 chapters have been thoroughly revised and 10 new monographs have been added. These monographs and introductory statements are based on a thorough review and evaluation by the Council on Drugs and its consultants of all of the laboratory and clinical information, including unpublished data, available to them. Thus, the book presents a concise, unbiased assessment of the newer drugs within the perspective of the therapeutic application of all of the commonly used agents in a particular class of drugs. Since a monograph on a drug is included whether or not the Council's opinion is favorable, *New Drugs* is in no sense a list of approved or accepted drugs.

The index lists drugs by both their nonproprietary (generic) and trade names and includes therapeutic entries. A list of Canadian trade name equivalents is given in the appendix.

CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS

M. H. Grieco (St. Luke's Hospital Center, New York).
Arch. Intern. Med. 119:141-146, (Feb.), 1967.

Direct intracutaneous tests for skin sensitizing antibody were performed with several penicillin and cephalosporin derivatives in a 37-year-old man studied five months after an anaphylactic reaction to a 125 mg. tablet of penicillin G. Skin sensitizing antibody was detected against both 6-amino-penicillanic acid and 7-aminocephalosporanic acid as well as to five semisynthetic penicillins and two semisynthetic cephalosporins. Three case reports in the literature described anaphylactic reactions to cephalothin in patients with penicillin allergy, while two studies in rabbits

support cross-sensitivity. In view of this apparent cross-reactivity, cephalosporin C derivatives should be used with the caution as penicillin derivatives are in patients with a history of penicillin allergy.

TOXIC EPIDERMAL NECROLYSIS: THE SCALDED SKIN SYNDROME

J. P. Anderson and D. A. Hillman (300 Longwood Ave.,
Canad. Med. Assoc. J. 95:1076-1079, (Nov. 19), 1966

Toxic epidermal necrolysis is a condition which can occur in all age groups and resembles skin scalding. It presents a generalized, markedly tender erythema of the skin with rapid progression to bullous desquamation of superficial layers and systemic toxicity. The condition was first described in 1956. A review of the literature shows that the incidence or recognition is increasing. The etiology has not been established, but may represent unusual hypersensitivity in certain individuals to drug, bacterial, or immunization factors. The mortality rate is approximately 50% of reported cases, with young children and debilitated adults at greater risk. Two children were recently successfully treated with this condition by using protective isolation, intensive nursing, intravenous antibiotics and hydrocortisone hemisuccinate. Early recognition of the disease and early use of corticosteroids inhibit the progression of epidermal necrolysis and improve prognosis.

CLINICAL STUDIES WITH CEPHALOTHIN

F. M. Wilson, J. W. Retan, and M. Lerner (Dept. of Medicine, Wayne State Univ. School of Medicine, Detroit)
J. Urol. 96:534-540, (Oct.), 1966.

Cephalothin was used to treat 13 patients for various infections who had previous probable urticarial reactions to penicillin. Eleven courses of therapy were completed without event, while during two courses rashes developed. An additional 16 patients with urinary tract infection (usually resistant to demethylchlortetracycline) were treated with cephalothin; eight of them who had urinary obstruction remained abacteriuric after six to 12 months. Serum and urine levels of cephalothin were determined in patients with gradation of elevation in their BUN, in one who was oliguric and in another completely anuric patient. The serum levels of cephalothin were higher in these patients and the half-life of the drug was 32 hours in the one patient completely without renal flow.

USE OF CHLORPROPAMIDE IN TREATMENT OF DIABETES IN PREGNANCY

C. P. Douglas and R. Richards (Royal Free Hosp. Medical School, Liverpool Rd., Islington, London)
Diabetes 16:60-61, (Jan.), 1967.

The use of chlorpropamide in a diabetic clinic led to its use in an associated antenatal clinic. In the care of the diabetic patients in pregnancy, those with prediabetes are included. The results in 128 pregnancies are given, 34 being treated with chlorpropamide. The administration started at various stages of pregnancy, and no harmful effects such as fetal loss or congenital anomaly were noted. Dosage in most cases did not exceed 200 mg per day.

A TEN-YEAR EXPERIENCE WITH CARCINOMA OF THE PANCREAS

J. H. Foster (Hartford Hosp., Hartford, Conn.)
Arch. Surg. 94:322-325, (March), 1967.

A total of 564 patients with a diagnosis of pancreatic adenocarcinoma were treated at seven hospitals during the ten-year period.

"My Suction Socket Leg Is So Neat ..."

...that it makes a more natural appearance. My clothes fit better, for without belts and straps I wear the proper size skirts and dresses. My Suction Socket Leg is more comfortable and easier to use, and I can walk greater distances without tiring and climb hills easier." Many other wearers are also enjoying the freedom of this new Hanger Limb. Our record of 90% success with Suction Socket Wearers is due to careful preliminary examination and expert fitting.

HANGER
ARTIFICIAL LIMBS

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

1293

patients had changes in the colon, 11 of them in combination with changes in the small intestine. Initial symptoms were fatigue and loss of appetite, and abdominal pain was often the dominating feature. There was retarded statural growth with non-appearance of adolescence in five cases, and perianal abscess or fistula, or both, in six cases. Segmentally increased haustration followed by dehausturation and mucosal sores were characteristic features in the roentgenograms, as were "skip areas" (six cases) and a cobblestone pattern (13 cases). Difficulties may be experienced in the differential diagnosis between this disease and ulcerative colitis. Thirteen patients were treated surgically, indicated by chronic disease which did not improve or became worse on medication. Surgery aimed at resection of diseased tissue with maintenance as far as possible of intestinal continuity. Pancoloproctectomy and ileostomy were performed in five cases. Eight of the surgically treated patients are symptom-free, three have only inconsiderable symptoms, two show little improvement, and three recurrences have occurred.

MEDIASTINOSCOPY WITH LYMPH NODE BIOPSY IN DIAGNOSIS OF SILICOSIS

M. Lob (Grand Chene 8, Lausanne, Switzerland), J. Pettavel, and D. Gardiol

Schweiz. Med. Wschr. 97:179-181, (Feb. 11), 1967.

Three cases of pulmonary silicosis are described in which lymph node biopsy by means of mediastinoscopy showed silicotic lesions. The indications and the limits of this method in diagnosing silicosis are discussed.

ETIOLOGY OF CORONARY HEART DISEASE IN WOMEN

R. Mulcahy, N. J. Hickey, and B. J. Maurer (Coronary Heart Diseases Research Unit, St. Vincent's Hosp., Dublin)

J. Irish Med. Assoc. 60:23-29, (Jan.), 1967.

Seventy-seven women with classical coronary heart disease were studied in an attempt to identify etiological factors. The two dominant factors were hypertension and cigarette smoking, these being present together or separately in 80% to 90% of the subjects. Three patients were diabetics; four had grossly abnormal serum cholesterol levels, and there was one case each associated with myxedema, aortic stenosis, and postoperative hypotension. Comments are made about the role of family history, obesity, hypercholesterolemia, abnormal glucose tolerance and dietary experience. The proper control of hypertension in the population and the elimination of cigarette smoking would cause a dramatic reduction in the incidence of precocious and middle-aged coronary heart disease in women.

DIAGNOSTIC PROBLEMS IN RETROPERITONEAL INTESTINAL RUPTURES

J. Hoferichter (Chir. Universitätsklinik, Krankenhausstr. 12, Erlangen, Germany)

Munchen. Med. Wschr. 109:346-348, (Feb. 17), 1967.

Retroperitoneal intestinal ruptures seldom occur but are frequently fatal injuries after blunt abdominal trauma. The author encountered seven cases among 93 surgically treated abdominal injuries; four had a fatal outcome. Difficulty in recognizing this lesion delays the urgent indication for surgery. Definite peritoneal signs develop only late and are then masked by other injuries, especially of the vertebral column and the kidneys, or they are misinterpreted as such. The only characteristic hint is the successive deterioration of the general condition of the patient, without specific symptoms. Even during laparotomy these injuries may be overlooked. After every abdominal injury the retroperitoneal space should be examined carefully. ◀

VALIUM® (diazepam)Roche®

Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Infants, patients with history of convulsive disorders, glaucoma or known hypersensitivity to drug.

Warning: Not of value in the treatment of psychotic patients, and should not be employed in lieu of appropriate treatment.

Precautions: Limit dosage to smallest effective amount in elderly or debilitated patients (not more than 1 mg, one or two times daily initially) to preclude ataxia or oversedation, increasing gradually as needed or tolerated. As is true of all CNS-acting drugs, until correct maintenance dosage is established, advise patients against possibly hazardous procedures requiring complete mental alertness or physical coordination. Driving during therapy not recommended. In general, concurrent use with other psychotropic agents is not recommended. If such combination therapy is used, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), such as phenothiazines, barbiturates, MAO inhibitors and other antidepressants. Advise patients against simultaneous ingestion of alcohol or other CNS depressants. Safe use in pregnancy not established. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Observe usual precautions in impaired renal or hepatic function. Periodic blood counts and liver function tests advisable in long-term use. Cease therapy gradually.

Side Effects: Side effects (usually dose-related) are fatigue, drowsiness and ataxia. Also reported: mild nausea, dizziness, blurred vision, diplopia, headache, incontinence, slurred speech, tremor and skin rash; paradoxical reactions (excitement, depression, stimulation, sleep disturbances, acute hyperexcited states, hallucinations); changes in EEG patterns during and after drug treatment. Abrupt cessation after prolonged overdosage may produce withdrawal symptoms (convulsions, tremor, abdominal and muscle cramps, vomiting, sweating) similar to those seen with barbiturates, meprobamate and chlordiazepoxide HCl.

Dosage—Adults: Mild to moderate psychoneurotic reactions, 2 to 5 mg b.i.d. or t.i.d.; severe psychoneurotic reactions, 5 to 10 mg t.i.d. or q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; muscle spasm with cerebral palsy or athetosis, 2 to 10 mg t.i.d. or q.i.d. *Geriatric patients:* 1 or 2 mg/day initially, increase gradually as needed and tolerated. (See Precautions)

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 50 and 500.



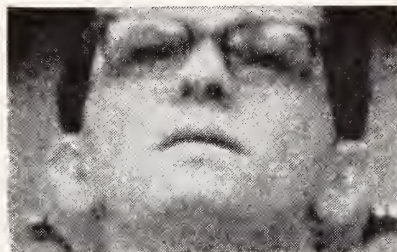
Roche Laboratories
Division of
Hoffmann-La Roche Inc.
Nutley, N.J. 07110



IMPORTANT NEW INSIGHTS INTO HUMAN RESPONSE TO EMOTIONAL STRESS:

New confirmation of the effectiveness of
Valium® (diazepam)

Ask your Roche representative to arrange a presentation of this important and fascinating research into certain somatic responses to emotional stress . . . quantitative, objective measurement with double-blind controls.



◀ Please see opposite page for important prescribing information.



. . . Bacteriological findings in chronic otorrhea are not very trustworthy because of contamination from without, but the organism grown from the first rush of pus after paracentesis, or immediately after the membrane has ruptured, will usually prove to be the causative organism.

If the streptococcus is found and the inflammation does not rapidly subside after drainage is established, immediate operation is indicated, as the streptococcus causes very rapid destruction of the soft parts and of the bony structure as well. (Streptococcus pus is usually thin and serous.) The inner table of the temporal bone, separating the antrum and meninges, and in the region of the tegmen; also the plate separating the antrum from the facial nerve, are of extreme thinness, and the rapid necrosis produced by the streptococcus and pneumococcus may give an opening into the brain with resulting brain abscess. The pus usually collects in the subdural space, from which it is carried by veins, arteries and lymphatics into the deeper structures.

The peculiar danger of pneumococcus infection is its liability to recurrence. The infection may apparently subside and the process heal, and these organisms remain inactive until healing is accomplished, then suddenly become active again, producing a reinfection. . . . H. K. Langdon, M.D., "The Bacteriology of Mastoiditis," *JISMA*, September, 1917.



**rouTINE TB screening with
TUBERCULIN, TINE TEST**
(Rosenthal) Lederle

A method so rapid and simple that you just *swab... uncap...press...and discard.*

Results, read at 48 to 72 hours, are comparable in accuracy to those of older standard intradermal tests. The self-contained, disposable unit requires no refrigeration and is stable for two years. Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in boxes of 5 and cartons of 25.

 **LEDERLE LABORATORIES**, A Division of
American Cyanamid Company, Pearl River, N.Y.
448-7-4985



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director



40th Anniversary of Coleman Hospital Will be Observed October 20 at Dinner

The fortieth anniversary of the William H. Coleman Hospital for Women at the Indiana University Medical Center will be observed Friday, October 20, with a dinner program at Marott Hotel.

More than 65,000 persons have been born at Coleman Hospital, the only one for women in the state. Further information may be obtained from the Department of Obstetrics and Gynecology, I. U. School of Medicine, 1100 W. Michigan St., Indianapolis 46207.

Dr. Levkoff is Speaker

Dr. Abner H. Levkoff, South Bend, recently spoke at the 11th Annual Congress of the Illinois Association for Maternal and Child Health in Peoria, Ill. Dr. Levkoff discussed the diagnosis and management of low birth weight babies.

"The Story Behind the Story of Great Moments in Medicine" is Topic for Talk

Mr. George A. Bender, of Parke, Davis & Company, will be the principal speaker at the October 12 meeting of the John Shaw Billings History of Medicine Society. His topic will be "The Story Behind the Story of Great Moments in Medicine."

The group meets at the I.U. Student Union Building, Indianapolis. Social hour begins at 6:00 p.m., dinner at 6:45 and the speaker at 8 p.m.

Dr. Langohr Showed Travelogue

Dr. John L. Langohr, Columbia City, recently presented a travelogue of his trip to the Orient before the Rotary Club of Columbia City. While in the Pacific area, he attended a series of seminars dealing with surgical practices and technics.

Eleventh Annual Fellowship Program Announced by Wyeth Laboratories

Applications for two-year Wyeth Pediatric Fellowships are now available. This will be the eleventh group of Fellowships, each

of which provides \$4,800 over a two year period toward advanced training.

Wyeth payments are in addition to normal resident stipends. Applications may be obtained by writing Dr. Philip S. Barba, 120 Erdenheim Rd., Philadelphia 19118.

Dr. Bristol Elected

Dr. H. M. S. Bristol, Terre Haute, has been elected vice-president to the Advisory Council of Vigo County Board of Health.

ISMA Joins Indiana Interagency Council on Smoking and Health

ISMA is one of sixteen Indiana health and education organizations which recently formed the Indiana Interagency Council on Smoking and Health.

The purpose of the organization is to provide a unified, coordinated force to more effectively inform the people of the state regarding the harmful effects of tobacco use, especially cigarette smoking, with emphasis on young people. Allan C. Erickson of the American Cancer Society is chairman.

Dr. Simmons Re-elected

Dr. James E. Simmons, Indianapolis, has been re-elected vice-president of the Indiana Mental Health Association.

Dr. Culbertson Accepts AMA Award For Lilly Research Team's Exhibit

The Hektoen bronze medal for an outstanding research exhibit at the 116th annual convention of the American Medical Association in Atlantic City was awarded to a group of scientists headed by Clyde G. Culbertson, M.D., research advisor in biology and a pathologist of the Lilly Research Laboratories in Indianapolis.



The exhibit relates to Dr. Culbertson's discovery that certain strains of free-living, or nonparasitic, amoebas can cause disease in animals and the group's subsequent demonstration that this occurs in both animals and man.

Free-living amoebas are present in the soil in many parts of the world. They feed on live bacteria and fungi.

Dr. Culbertson, as senior investigator, accepted the medal for the research team at an AMA awards banquet. The other researchers in-

involved in the investigation were Paul W. Ensminger and Willis M. Overton II, of the Lilly biological research division; Henry R. Black, M.D., of the Lilly Laboratory for Clinical Research; and Cecil G. Butt, M.D., of the Orange Memorial Hospital, Orlando, Florida.

Two common strains of amoebas — *Hartmannella* and *Naegleria* — were found to be implicated in human meningoencephalitis.

The Lilly exhibit shows how the disease can be diagnosed, but so far no completely satisfactory treatment has been found.

The study was begun nearly ten years ago when Dr. Culbertson became interested in the presence of amoebas in tissue cultures.

RUNNER-UP Bert MacWilliams (left) congratulates Dr. Thomas N. Davis III, of Hammond, who won the lawn bowls singles competition in the Central Division Tournament of the American Lawn Bowls Association in Detroit. Dr. Davis, a member of the Chicago Lakeside Lawn Bowling Club, won the finals 21 to 9 against MacWilliams. The lawn bowling competitors were from Wisconsin, Illinois, Indiana, Ohio, Michigan and Canada.



Suspecting that they might be agents for infection, he initiated an investigation.

He found it was possible to produce experimental brain disease in animals by inoculating the nasal passages with amoebas. The study was expanded and other pathologists were asked to help look for the disease in man. As a result, a small number of cases of amoebic meningoencephalitis were found in such widely scattered locations as Australia, Florida and Virginia.

Further investigation is under way into the possible role of these amoebas in the cause of other disorders.

Dr. Province Elected

Dr. William D. Province, Franklin, has been re-elected to a four-year term as health officer of Johnson county.

Indiana Medical Record Specialists Attend Data Processing Institute

Five medical record specialists from Indiana attended a recent three-day data processing institute conducted by the American Association of Medical Record Librarians. New methods of collecting and retrieving data for statistical purposes were studied.

Mary Cappel of Fayette Memorial Hospital, Connersville; Freeda Stearley of Union Hospital, Terre Haute; Sister Mary Alphonsetta Hodges of St. Margaret Hospital, Hammond; and Gertrude L. Gunn and John P. Garrison, both of the Indianapolis Hospital Development Association, attended.

Doctors Are Speakers

Drs. Sanford C. Snyderman and Charles S. Giffin, Fort Wayne, spoke on "Oral Lesions" at a recent meeting of the Fort Wayne Academy of Medicine and Surgery.

Publication Announced of New Book, "Wilbur J. Cohen: Pursuit of Power"

Marjorie Shearon's new book on "Wilbur J. Cohen: Pursuit of Power" is now available. The paperback edition is sold at \$2.50,

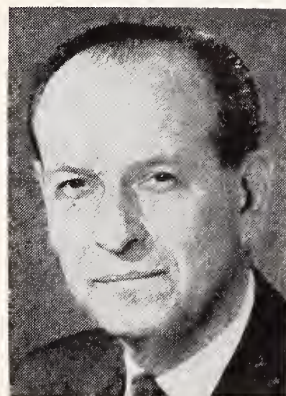
the library edition for \$3.50, with discounts for quantity orders. Write Shearon Legislative Service, 8801 Jones Mill Rd., Chevy Chase, Md. 20015.

Dr. Bannon is Speaker

Dr. William G. Bannon, Terre Haute, spoke on "The Medical Doctor" at a recent health careers day at Otter Creek Junior High School.

Dr. Mark I. Hewitt Appointed 3M Director of Clinical Research

Dr. Mark I. Hewitt, former South Bend physician, has been appointed director of clinical research of the 3M Company, St. Paul, Minnesota.



Dr. Hewitt came to 3M after more than a dozen years as medical director and clinical research director with major pharmaceutical companies. He earlier engaged in the private practice of medicine and internal medicine at South Bend, Ind., and served four years with the U. S. Army Medical Corps.

A 1937 graduate of the Indiana University School of Medicine, he is a member of the American College of Clinical Pharmacology and Chemotherapy, the Drug Information Association, the American Medical Association and other professional groups.

Dr. Cristee is Speaker

Dr. James W. Cristee, Terre Haute, spoke on diabetes at a recent meeting of the Wabash Senior Citizens.

"The Battle for Clean Air" is New Public Affairs Pamphlet

"The Battle for Clean Air" is the title of a Public Affairs Pamphlet just issued. The 28-page booklet is an explanation in

**In Obesity,
anorectic action
with fewer unwanted
side effects**



CYDRIL®

(levamfetamine succinate TUTAG)



**Cydril at 2 p.m.
Appetite control at 6
Sleep at 10**

Action and Uses: Cydril (levamfetamine succinate) is a chemo-pharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or your colleagues)



S.J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234

lay terms of the problem of atmospheric pollution.

The pamphlet (No. 403) is available from Public Affairs Pamphlets, 381 Park Ave., South, New York 10016, at 25 cents per copy and with discounts for large orders. It is recommended for public education campaigns.

Dr. Griffin Inducted

Dr. Joseph P. Griffin, Chesterton, recently was inducted into the American Academy of Allergy at a meeting in Palm Springs.

New Film Available for Showing To Nurses, Other Paramedical Personnel

The Public Health Service has for free short-term loan a 16 mm, black and white, sound, movie film entitled "To Face Life Again: Rehabilitation through Reconstructive Plastic Surgery."

It is suited for showing to nurses, social workers and other paramedical personnel. Write Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Dr. Schnute is Speaker

Dr. Richard B. Schnute, Indianapolis, spoke on "Glandular Diseases" at a recent meeting of the members of St. Mary's hospital medical staff in Evansville.

New Medical Teaching Film on Nutritional Therapy Now Available

A medical teaching film "Nutritional Therapy — Some New Perspectives" has been produced by and is obtainable from E. R. Squibb & Sons.

The film is in the nature of a report on current aspects in four different areas of nutritional therapy, discussed by five clinicians. It is in color, with sound, runs for 43 minutes, 16 mm size. Write Squibb at 745 Fifth Ave., New York City 10022.

Dr. Lindgren is Speaker

Dr. Ivan T. Lindgren, Lawrenceberg, spoke on the topic of "Cancer" at a recent Dillsboro PTA meeting.

Indiana Physicians Named to Positions on AMA Scientific Sections

Dr. Lester Hoyt, Indianapolis, was chosen chairman of the AMA Section on Pathology and Physiology at the recent meeting in Atlantic City.

Dr. Sprague Gardiner, Indianapolis, and Dr. Myron Nourse, Indianapolis were elected as alternate delegates respectively for the AMA Section on Obstetrics and Gynecology and the AMA Section on Urology.

Dr. Lehman Guest Speaker

Dr. Kenneth Lehman, Topeka, spoke on his recent trip to Vietnam at a recent Book Guild meeting in LaGrange.

Purdue University Recipient of Health Sciences Advancement Award

Purdue University is the recipient of one of five Health Sciences Advancement Awards from the Public Health Service. Its award

JOURNAL of the Indiana State Medical Association

for \$695,000.00 is for broad, wide-ranging studies in neurobiology — research in preception, in memory, and in the relationship of nervous system activity to behavior.

Dr. Moss Heads Board

Dr. Mavor J. Moss, Yorktown, has been elected to a two-year term as chairman of the Indiana State Board of Health.

Dr. Hoyt is Speaker

Dr. Lester H. Hoyt, Indianapolis, spoke on "Opportunities and Salaries in Medical Technology" at a recent open house held for college students and high school juniors and seniors at Methodist Hospital.

Doctors Attend Sessions

Drs. W. B. Wilson and Dan L. Urschel, Mentone, recently attended the clinical sessions of the Indiana Flying Physicians Chapter in Fort Wayne.

Clinical presentations were made by **Drs. J. E. Arata, Jack Patterson, Roger Smith, Franklin Bryan, and Joe G. Jontz, all of Fort Wayne**. Dr. Urschel acted as moderator of a panel on "Management of A-V Heart Block."

Dr. Lehman Shows Slides

Dr. Kenneth M. Lehman, Topeka, showed slides of his recent trip to Vietnam at recent meetings of the LaGrange Exchange Club and the Aldersgate Methodist Church.

Dr. Ellis Speaks to Nurses

Dr. F. D. Ellis, North Vernon, spoke on "Jaundice — Methods of Treatment and Prevention" at a recent meeting of the Jackson County Nurses Association.

Dr. Yegerlehner Honored

Dr. Roscoe S. Yegerlehner, Kentland, recently appointed to the Purdue Student Health Center at Purdue University, was honored with a surprise farewell party by employees of the George Ade Memorial Hospital.

Dr. Salon Appointed

Dr. Nathan L. Salon, Fort Wayne, was recently appointed to the Fort Wayne Housing Authority.

Gary Nurse Appointed to Term On National Board of Directors

Mrs. Helen M. Fusiek of Gary, president of the Indiana State Licensed Practical Nurses Association, has been appointed to a one-year term on the Board of Directors of the National Association for Practical Nurse Education and Service.

Dr. Cristee Speaks

Dr. James W. Cristee, Terre Haute, spoke on "Diet in the Treatment of Diseases" at a recent meeting of the West Central Indiana Dietetic Association.

Public Health Service Will Loan Free Film on Solid Waste Disposal

The Public Health Service will loan free of charge on a short term basis a training film on the disposal of solid waste. It is in-

removes the mental blur



that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s
Solfoton Capsules (yellow and brown)
100s, 500s, 1000s
Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



"I've been doing my own doctoring . . . I took myself off one-a-day vitamins and put myself on five-a-day drinks!"

tended for the general public. It is 16 mm, in color, with sound and runs for 23 minutes.

The film is recommended for showing to civic groups, high school and college students, and to public health and municipal officers. Write the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Dr. Guild Honored

Dr. J. Kent Guild, Plymouth, recently was named as one of five Outstanding Young Men of Indiana for 1966 by the Indiana Junior Chamber of Commerce.

National Appointments Announced To Blue Shield Board of Directors

Dr. Guy Owsley, Hartford City, was recently reappointed to a one-year term on the Board of Directors of the National Association of Blue Shield Plans by the AMA Council on Medical Service.

Richard C. Kilborn, Indianapolis, president of Indiana Blue Shield, was also elected to the board as a plan executive director from District VII.

1968 AAPS Essay Contest For High School Students

The Association of American Physicians and Surgeons is conducting its 22nd Annual National Essay Contest for high school students and invites county medical societies to cooperate and sponsor the local contests. Those interested should write the Association at 230 N. Michigan Ave., Chicago 60601. ◀

HARDING HOSPITAL, Inc.

(Formerly Harding Sanitarium)

WORTHINGTON

OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

GEORGE T. HARDING, M.D.

Medical Director

JAMES L. HAGLE, M.B.A.

Administrator

Phone: Columbus 614-885-5381

Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING

Date November 26-29, 1967
Place Houston, Texas

INDIANA STATE NURSES ASSOCIATION

Date Oct. 12-14, 1967
Place French Lick-Sheraton Hotel, French Lick

INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 9-12, 1967
Place Indianapolis

NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER

Date May 17-18, 1968
Place Stouffer Inn, Indianapolis

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.

Date December 2, 1967
Place Indianapolis Motor Speedway Motel, Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION

Date Second Wednesday of the month, October through May, excluding December
Place The Athenaeum, Indianapolis

BONE AND JOINT CLUB

Date October 18, 1967
Place Athenaeum, Indianapolis

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Date January 10, 1968
Place Stouffer Inn, Indianapolis

INDIANA ROENTGEN SOCIETY

Date October 10, 1967
Place Murat Theater, Indianapolis

INDIANA ACADEMY OF GENERAL PRACTICE

Date March 26-28, 1968
Place Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS

Date May 25-26, 1968
Place Marott Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION

Date Nov. 1-3, 1967
Place French Lick-Sheraton Hotel, French Lick

INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Date May 1-2, 1968
Place Culver Inn, Culver

INDIANA STATE DENTAL ASSOCIATION

Date May 19-20, 1968
Place Murat Theater, Indianapolis

REGENTS MEETING OF THE INDIANA CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

Date November 11, 1967
Place Holiday Inn, Bloomington

BRACES

ARTIFICIAL LIMBS

SURGICAL APPLIANCES

CORRECTIVE SHOES

CENTRAL BRACE & LIMB CO., Inc.

1901 N. Capitol Ave.
Indianapolis, Ind. 46202
925-4296

406 S. BERKLEY RD.
Kokomo, Ind. 46901
457-4868

CERTIFIED BRACE FACILITY — MODERN PROFESSIONAL OFFICES

MEN AND LADY FITTERS



when he just can't sleep
Tuinal

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, $1\frac{1}{2}$, and 3-grain Pulvules**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206



700955

Disease	July 1967	June 1967	May 1967	July 1966	July 1965
Animal Bites	1245	1626	955	967	1077
Chickenpox	49	117	274	75	110
Conjunctivitis	98	61	81	85	96
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	26	9	21	44	40
Gonorrhea	425	445	371	338	317
Impetigo	116	75	54	130	156
Infectious Hepatitis	23	36	52	30	47
Infectious Mononucleosis	33	34	64	45	38
Influenza	27	50	277	112	205
Measles (Rubeola-Rubella)	55	122	216	322	144
Meningitis, Meningococcal	1	1	6	1	3
Meningitis, Other	7	1	5	4	3
Mumps	261	509	665	81	116
Pertussis (whooping cough)	54	22	20	32	10
Pneumonia	109	204	143	153	124
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	220	277	417	238	421
Syphilis					
Primary & Secondary	13	16	9	9	1
All Other Syphilis	74	231	100	86	81
Tinea Capitis	6	10	2	5	16
Tuberculosis (Active)	70	113	77	83	75

*When the problem
is only skin deep*

USE 'POLYSPORIN'[®] brand POLYMYXIN B-BACITRACIN OINTMENT

**for topical antibiotic therapy with minimum
risk of sensitization**

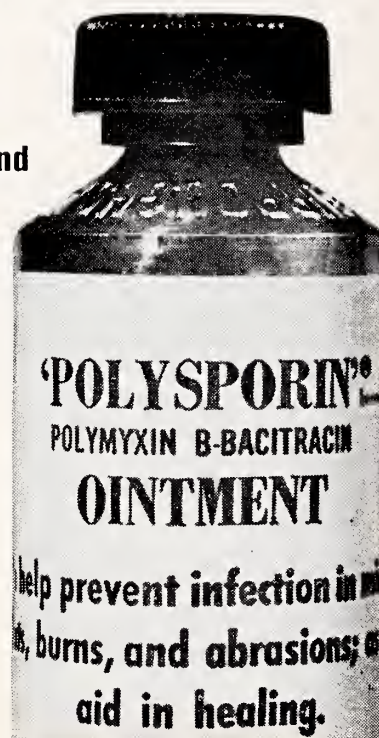
Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

Supplied in 1/2 oz. and 1 oz. tubes.

Complete literature available on request from Professional Services Dept. PML.



BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



This "case history" runs to some 10,000 pages

This is a typical "case history" of one new drug — or, rather, a proposed new drug — assembled for submission to the U. S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial invest-

ment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers — a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.



**Pharmaceutical
Manufacturers Association**

**Pharmaceutical
Advertising Council**

1155 Fifteenth St., N. W., Washington, D.C. 20005



This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

FUTURE MEETINGS, SEMINARS, COURSES

"Surgery of the Hand" Postgraduate Course at the University of Colorado

"Surgery of the Hand" will be the subject of a four-day postgraduate course at the University of Colorado School of Medicine in Denver, from February 20 to 23, 1968.

For details write Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Mayo Clinic Announces Two Sessions of Clinical Reviews

Clinical Reviews will be presented by the Mayo Clinic in the fall this year. The dates are November 6, 7 and 8, and again on November 13, 14 and 15. The two identical sessions are presented because of the popularity of the course in the past.

The number of physicians who can be accommodated is limited. Registration fee is \$10. Credit is authorized by the American Academy of General Practice. Further information and registration may be obtained by writing to M. G. Brataas, Mayo Clinic, Rochester, Minnesota 55901.

Second International Congress of Lymphology Will be May 15-20, 1968

The Second International Congress of Lymphology will be held on May 15 to 20, 1968 at the Fontainebleau Hotel, Miami Beach, Florida, under the auspices of the University of Miami School of Medicine.

Write Dr. Manuel Viamonte, Jr., 1450 N. W. 11th Ave., Miami, Florida for more information.

Cleveland Clinic Educational Foundation Announces Postgraduate Course for 1967

The Cleveland Clinic Educational Foundation will present a postgraduate course in "Selected Topics in Nursing" October 18 at Cleveland.

Further information on the course may be obtained by writing the Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

Medical Writers' Institute Sets Annual Teaching Seminar October 23

The Medical Writers' Institute will conduct its annual teaching seminar at the Princeton Club in New York City on Monday, October 23.

Outstanding speakers are on the program. A workshop and roundtable conference are included. Those interested should write Dr. Joseph Franklin Montague, 104 E. 40th St., New York City 10016.

ISMA Members Invited to Attend Interim Clinical Meeting

Members of ISMA are invited to attend the Interim Clinical Meeting of the American College of Chest Physicians at the Warwick Hotel, Houston, Texas, November 25 and 26.

Program will be a two-day scientific presentation with roundtable discussions and fireside conferences. There will be a panel discussion held at the NASA Manned Spacecraft Center. For further details write the College at 112 E. Chestnut St., Chicago 60611.

"Frontiers of Medicine, 1967-1968" Will be Presented Beginning in October

"Frontiers of Medicine, 1967-1968" will be presented by the Committee on Continuing Medical Education of the University of Chicago, beginning on October 11 and continuing once a month for a total of eight meetings.

A program and reservation card may be obtained by writing Frontiers of Medicine, 950 E. 59th St., Chicago 60637. ◀

INDIANA MEDICAL BUREAU
816 Hume Mansur Bldg.
634-5804

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 16th Year Of Service

Deaths

William G. Cullogen, M.D.

Dr. William G. Cullogen, retired Indianapolis physician, died July 17 at the age of 92 at Indianapolis.

A general practitioner for 65 years, Dr. Cullogen started his practice at Avon but soon came to Indianapolis. He did not close his office until three years ago. Graduated from the Vanderbilt University School of Medicine in 1899, Dr. Cullogen was a member of the staffs of Methodist and St. Vincent's Hospitals, the ISMA 50-Year Club and the Marion County Medical Society. He was made a Senior Member of ISMA in 1964.

Edmund Adler, M.D.

Dr. Edmund Adler, 57, former member of the Lake County Medical Society and resident of Dyer, died July 21 in Park Forest, Ill.

A general practitioner, Dr. Adler was graduated from the University of Illinois in 1939. He lived in Dyer for 11 years and was a staff member of St. James Hospital in Chicago Heights, Ill.

Everett L. Hays, M.D.

Dr. Everett L. Hays, retired Indianapolis general practitioner, died July 19 in the Veterans Administration Hospital in Marion. He was 73.

Graduated from the I.U. School of Medicine in 1919, Dr. Hays was a lifelong resident of Indianapolis. He was a flight surgeon during World War II, retiring with the rank of captain from the Naval Reserve in 1946. He was on the staff of Central State Hospital from 1946 until his retirement in 1963. He was a Senior Member of ISMA and a member of the Marion County Medical Society.

Charles F. Overpeck, M.D.

Dr. Charles F. Overpeck, 75, who retired in April after 40 years as a general practitioner in Greensburg, died August 2 at his home.

A Parke County native, Dr. Overpeck came to Greensburg in 1926, a year after he was graduated from the I.U. School of Medicine. He had served several terms as Greensburg city health officer and as Decatur County coroner. A member of the Decatur County Medical Society, Dr. Overpeck served as its secretary and presi-

dent, was on the Council and several ISMA committees and was an ISMA delegate. He was also a Senior Member of ISMA.

John P. Showalter, M.D.

Dr. John P. Showalter, 60-year-old Waterloo general practitioner, died July 22 in Auburn.

Dr. Showalter practiced medicine at Waterloo for 30 years before retiring in 1963 because of ill health. Graduated from the I.U. School of Medicine in 1932, Dr. Showalter was a member of the De Kalb County Medical Society, had served as the society's secretary from 1935-38 and was an ISMA delegate in 1944.

William E. Symon, M.D.

Dr. William E. Symon, physician at the Caylor-Nickel Clinic, Bluffton, died July 30 there.

A native of Garrett, Dr. Symon was graduated from the I.U. School of Medicine in 1952. He joined the Caylor-Nickel staff on 1956, specializing in hematology. A Fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine, Dr. Symon was a member of the Wells County Medical Society and had served as its secretary. ◀

SYMPOSIUM ON CLINICAL PROBLEMS

November 15, 1967

Marott Hotel, Indianapolis

(Approved by AAGP for 4 Prescribed Hours Credit)

Registration — Lobby of Marott Hotel, 9:00 a.m.

MORNING SESSION MODERATOR: Jerome E. Holman, Jr., M.D.

1. "USE OF ISOTOPES IN DIAGNOSIS AND TREATMENT" Philip T. Hudgins, M.D., Houston, Texas
2. "RECOGNITION OF VARIOUS PSYCHIATRIC PROBLEMS" Edwin M. Dunlop, M.D., South Attleboro, Mass.

LUNCHEON CHAIRMAN: James Young, M.D.

Luncheon Speaker: Mr. Chuck Werner, Indianapolis Star,

"POLITICS" (Wives invited)

AFTERNOON SESSION MODERATOR: Marvin C. Christie, M.D.

3. "EARLY SIGNS AND MANAGEMENT OF CORONARY DISEASE" Edward Massie, M.D., St. Louis, Missouri
4. "DIFFERENTIAL DIAGNOSIS OF JAUNDICE AND THE RELATIVE VALUE OF VARIOUS LIVER FUNCTION TESTS" George L. Jordan, M.D., Houston, Texas

Program Director is Dr. Joseph Ball of Indianapolis. This symposium is being held in cooperation with the Academy and the Marion County Medical Society with the assistance of Lederle Laboratories.

Association News

EXECUTIVE COMMITTEE

July 29, 1967

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D.; G. O. Larson, M.D.; Lowell H. Steen, M.D.; Ottis N. Olvey, M.D.; Lester H. Hoyt, M.D.

Frank B. Ramsey, M.D., editor, *The Journal*; Robert Robinson, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of	
December 31, 1966	4,409
1967 members as of	
June 30, 1967:	
Full dues paying	3,842
Residents and interns	102
Council remitted	48
Senior	308
Honorary	3
Military	44
Total 1967 members as of	
June 30, 1967	4,347
Number of members as of	
June 30, 1966	4,348
Loss over last year	1
Members delinquent for 1967	68
Number of AMA members as of	
June 30, 1967	4,171
Total 1966 AMA members as of	
June 30, 1966	4,235
Loss over last year	64
1967 AMA members:	
Dues paying	3,668
Exempt, but active	503
	4,171
Number who have paid state dues	
but not AMA dues as of	
June 30, 1967	176
Number who paid state dues	
but not AMA dues as of	
June 30, 1966	113
1966 AMA members	
resigned for 1967	35

Headquarters Office

The proposal for enclosing the Medicare Department with a partition at a cost of \$537.00 was approved on motion of Drs. Rifner and Kintner.

Treasurer's Office

The treasurer's report of cash balances and investments was accepted by consent.

Legislation

National: The secretary reported on his contacts concerning H. R. 5710.

Local: The secretary reported that it appeared there would be a special session of the state legislature sometime this year and from what he could learn at this time

the legislature would take up issues other than redistricting. By consent it was agreed that the association should actively concern itself with the rewrite of a bill to implement Title XIX.

Organization Matters

A letter from Dr. Merritt Alcorn, president of the State Board of Medical Registration and Examination, was read in which he informed the association that the board was planning in the near future a conference on medical examinations and that the association would be notified when a date was definitely established.

A letter from Dr. C. Philip Fox concerning the action of the Daviess-Martin County Medical Society on the measles eradication program was read for the information of the committee.

A letter from Health Service Bureau of Milwaukee was read, announcing that the bureau was starting a campaign in Indiana to sell people on the Emergency Medical Identification System and would maintain people's health records in Milwaukee. No action was taken.

A letter from the Continental Casualty Company concerning their calling on physicians not eligible for the regular association plan was reviewed for the information of the committee.

A letter from the Indiana Civil Liberties Union, addressed to Governor Branigin, concerning his veto of H. B. 1621, the abortion bill, was reviewed for the information of the committee.

Dr. Steen commented that he had received a request for the establishment of a section in the Association on Directors of Medical Education, and such a resolution will be forthcoming for the annual meeting.

Upon motion of Drs. Rifner and Kintner, a \$25.00 assessment to the Joint Committee for the Improvement of Patient Care in Indiana was approved.

A letter from the Ball Memorial Hospital dealing with the corporate practice of medicine was reviewed and upon motion of Drs. Larson and Olvey, the procedure of the Florida Medical Association in this regard is to be referred to the chairman of the Council for proper disposition.

A letter from Dr. Daniel Bernoske concerning the recent conference to discuss the need for a statewide utilization review committee was read, in which Dr. Bernoske informed the association that the Division of Medical Care Administration of the Indiana State Board of Health proposed no changes in present operations.

A pamphlet distributed by the American Podiatry Association was reviewed for the information of the committee.

A letter from Dr. K. O. Neumann, ad-

dressed to Mr. Guy Spring, concerning the recent action of the Blue Cross Board on pre-surgical testing was reviewed for the information of the committee.

A release from the Department of HEW announcing the fact that the Indiana University School of Medicine had received a grant of \$384,750.00 for its regional medical program was reviewed for the information of the committee.

The speech made by Senator Vance Hartke opposing the efforts of the Internal Revenue Service to tax income from organizations such as the Indiana State Medical Association was called to the attention of the committee.

A letter from Dr. Glen Ryan concerning the recent action of the Executive Committee in regard to proposed changes in the bylaws of the American Association of Medical Assistants was reviewed and by consent this is to be brought up at the next meeting of the Executive Committee.

The secretary called to the attention of the committee the invitation from the American Medical Association to submit names to the AMA for openings on councils and committees, and by consent this was referred to the Council of the association.

A newspaper clipping announcing that 22 students and faculty members of the Palmer School of Chiropractic had been indicted for cheating on examinations was reviewed for the information of the committee.

Annual Convention, Indianapolis, October 9, 10, 11 and 12, 1967

The program for the annual convention was discussed and by consent it was agreed to change the time of the scientific program on Wednesday afternoon from 2:00 to 2:30 in order to permit ample time for the president's luncheon Wednesday noon. It was also agreed that the sports trophies should not be presented at the president's luncheon but that the committee should make other arrangements for distribution of these prizes.

A letter from the Fort Wayne Medical Society announcing its local convention arrangements committee for the 1968 convention was reviewed.

Blue Shield Matters

An excerpt from the National Blue Shield publication was read in which it was announced that Blue Shield is discussing with the government the possibility of the government purchasing prepaid insurance for Title 19 recipients.

A letter was read from Mr. Hollowell in which he announced that the state of Indiana had accepted the ISMA proposed

rewrite of the agreement between the State Department of Public Welfare and Blue Shield and Blue Cross.

The material concerning the new U. S. Steel contract was reviewed and it was noted that the contract was based on a prevailing fee concept. On motion of Drs. Steen and Larson, this matter was referred to the Council.

Letters from Drs. Charles Yale and Leo Brown were reviewed for the information of the committee as well as the secretary's letter of transmittal of these complaints to Blue Shield, and Blue Shield's reply stating that the matter had been straightened out.

A letter distributed by Blue Shield to physicians was read, announcing that under the General Motors program for its employees and under the provisions of Title 18, it would no longer be necessary for the physician to accept assignments in these cases.

The president reported on the action taken by the Blue Shield Board on Sunday, July 23, concerning pre-surgical workups, as proposed by Blue Cross.

Also brought up was the proposal of the Blue Shield to send a report form to

Union members when Blue Shield did not pay the claim in full. The committee objected to the explanation printed on the claim form, and upon motion of Drs. Rifner and Steen, this matter was referred to the Council.

New Business

A letter from the American Medical Association announcing that Mr. W. J. Brown had been assigned as AMA field representative for Indiana was reviewed. Mr. Brown will also cover the states of Michigan, Minnesota, and Wisconsin.

The notification of the Judicial Council of the AMA concerning professional courtesy was reviewed and on motion of Drs. Steen and Larson, this was to be referred to the Council with the recommendation that it be adopted as policy for physicians in Indiana.

The actions of the Board of Trustees of the American Medical Association at its recent meeting were reviewed for the information of the committee.

A letter from the American Medical Association concerning the proposed topics to be discussed at the annual PR Institute in August was reviewed and the commit-

tee felt that no changes were necessary.

The Journal

On motion of Drs. Larson and Rifner, the Business Manager and the Assistant Editor of *The Journal* were authorized to attend the 1967 Biennial Journal Conference in Chicago on September 18 and 19.

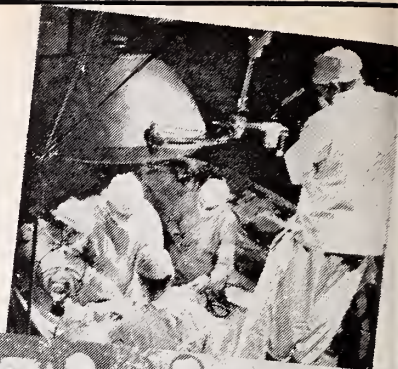
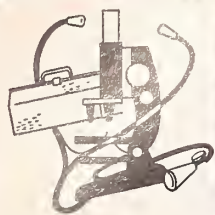
Future Meetings

Upon motion of Drs. Larson and Steen, Drs. Rifner, Larson, Steen, and the male staff of the association are authorized to attend the PR Institute in Chicago on August 24 and 25, 1967.

The notice of the meeting of the AMA Committee on Nursing, to be held in Chicago on October 6, 1967, was reviewed and it was decided that no one would be sent to this meeting.

Notice of the 2nd National AMA Conference on Utilization Review, to be held in Houston, Texas, on November 25, 1967, was reviewed for the information of the committee.

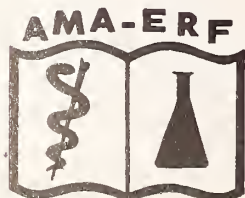
There being no further business the committee adjourned to meet again at 3:00 p.m. on Saturday, August 12, 1967. ◀



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

COMMERCIAL ANNOUNCEMENTS

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

EASTERN WISCONSIN CLINIC in rapidly growing community of 50,000 desires board-eligible or certified physicians in obstetrics and gynecology, pediatrics, orthopedic surgery, urology and otolaryngology. Well-equipped clinic and excellent hospital facilities. Lake shore location offers ample recreational facilities. Attractive financial plan leading to early full partnership. Full expenses paid for applicants invited to interview. Call or write: F. L. Hildebrand, M.D., Riverside Clinic, Menasha, Wisconsin.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION**, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

AVAILABLE: Office location for general practitioner or pediatrician. Attractive rental proposition. Located ten minutes from hospital in fastest growing township in Indiana. Contact R. A. Chronister, % Chronister Pharmacy, 6120 Stellan Rd., Fort Wayne, Ind. Telephone 219-483-9561.

GENERAL PHYSICIAN: \$1,540 to \$1,940 a month for regular duty hours in care of patients in a mental hospital. Previous psychiatry training not necessary. Citizenship and license in Indiana. Housing and living benefits on an individually determined basis. Write or phone collect to David P. Morton, M.D., Superintendent, Beatty Memorial Hospital, Westville, Indiana 46391. Phone: (219)-785-7111.

INTERNISTS: Unopposed practice opportunity in town of 17,000 with new 100-bed hospital. Office space immediately available in new professional building. General practitioners also needed. Contact P. E. Doermann, M.D., 1775 N. Jefferson, Huntington, Ind. 46750. Phone (219) 356-4520.

WANTED: G. P. for aggressive town of 1,300 in southern Indiana. New Sears-Roebuck medical clinic to be built in immediate future. Clinic available rent free first 90 days; reasonable rent thereafter or may purchase. Contact Gordon A. Triplett, Box 37, Osgood, Ind. 47037.

INDUSTRIAL PHYSICIAN: Head medical department in medium size Indiana plant. Fee paid by employer. Indiana Medical Bureau, 816 Hume Mansur Bldg., Indianapolis 46204.

POSITION AVAILABLE: For physician with some psychiatric training or experience to head a 24-bed intensive treatment psychiatric service; extensive training or experience not required; excellent opportunity to develop in the field of psychiatry in a city of 185,000 near Chicago and Detroit. Must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Excellent fringe benefits. Liberal salary range dependent on qualifications. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

WANTED: Pediatrician, certified or eligible, to associate with two certified pediatricians in upper midwest college city of 50,000. Write Box 345, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

INTERNIST: Position available for a Board Certified or qualified internist in a 200-bed modern, progressive general hospital with 104-bed medical service; fine opportunity in a city of 185,000 near Chicago and Detroit; liberal salary range dependent on qualifications; excellent fringe benefits; must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

FOR SALE OR RENT: G. P.'s office suite; building five years old; fully air conditioned; town of Mooresville, 18 miles from Indianapolis. Desperately in need of a G. P. Call 831-2484; 831-0874 or 839-2525.

SURGEON: 35-years-old; married; board eligible and Indiana licensed; desires location in association or hospital employment. Contact: Mostafa H. Bate, M.D., 1553 Virginia St., E., Charleston, W. Va. 25311.

PHYSICIAN

An Exciting New Career In The Health Field!!

Dynamic Internist or Pediatrician needed to serve as Medical Director for the Louisville Neighborhood Health Center.

This program is part of the new concept for delivering Comprehensive Health Services funded by the OEO. The Director will supervise a professional staff of 36 persons and will be involved in all of the new and interesting facets of this exciting program.

Salary . . . \$22,500-\$27,000+

with potential for advancement.

Curriculum Vitae to:

Dr. Harvey Sloane

1817 South 34th St., Louisville, Kentucky 40211

An Equal Opportunity Employer, M/F

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

September 1967

Volume 60

No. 9

Abbott Laboratories	1163-68	Medical Protective Co. of Ft. Wayne	1270
American Fletcher National Bank	1179	Merchants National Bank	1277
American Tobacco Company	1137	Mutual Medical Insurance, Inc.	1199
Burroughs Wellcome & Co., Inc.	1306	National Drug Company, The	1187
Carnation Company, The	1280-81	Parke, Davis & Company	2nd Cover
Central Brace & Limb Co., Inc.	1303	Philips Roxane Laboratories	1288-89
Dorsey Laboratories	1141-44	Pitman-Moore Company	1171
Dairy Councils in Indiana	1267	Poythress, Wm. P. & Co., Inc.	1262, 1301
Geigy Pharmaceuticals	1268-69, 1283-86	Professional Life & Casualty Company	1279
Hanger, J. E., Inc.	1292	Quality Leasing, Inc.	1293
Harding Hospital	1302	Robins, A. H. Company, Inc.	1153-54, 1271
Home Lawn Mineral Springs	1290	Roche Laboratories	4th Cover, 1294-95
Hynson, Westcott & Dunning, Inc.	1133	Rorer, William H., Inc.	1159
Indiana Bell Telephone Company	1266	Sandoz Pharmaceuticals	1260-62
Indiana Brace, Inc.	1282	Searle, G. D. & Co.	1188-89
Indiana Medical Bureau	1308	Stuart Company, The	1135
Indiana National Bank	1200	Syntex Laboratories, Inc.	1155-58
Kidney Foundation of Illinois	1291	Tutag, S. J. & Company	1300
Lederle Laboratories	1177-78, 1197, 1257, 1296	Wabash Valley Hospital	1150
Lilly, Eli & Company	1172, 1190-92, 1272-74, 1304-05	White-Haines Optical Co.	1139
		Winthrop Laboratories	1258-59
		Wyeth Laboratories	3rd Cover, 1146-47, 1182-83

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

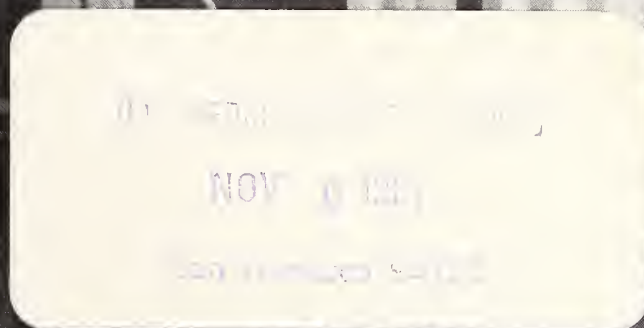
Indiana State Medical Association

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

Indianapolis, Indiana

October, 1967 Vol. 60 • No. 10



J-0-P
Univ Of Calif
Med Ctr Library
Acquisitions Dept
San Francisco, Calif 94122

12-67



Dilantin®

(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

015R67



BSP® DISPOSABLE UNIT

F&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



MSULPHALEIN®

I A COMPLETE,

STERILE,

DISPOSABLE,

ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

Each BSP Disposable Unit contains a sterile syringe with the 5 mg./kg. BSP dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized Bromsulphalein solution.

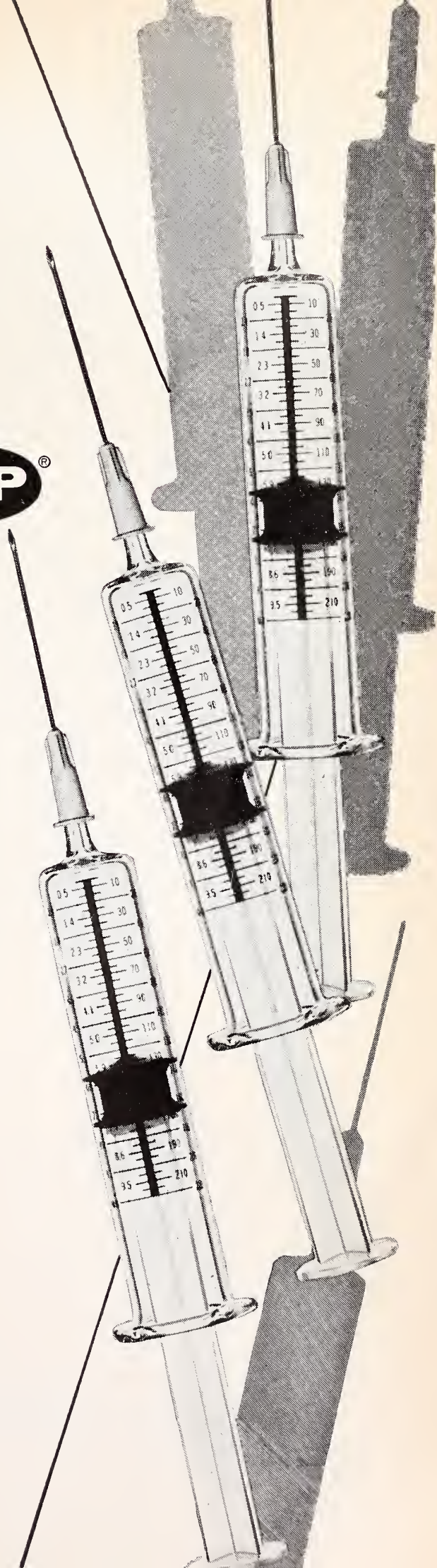
This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

LYNSON, WESTCOTT & DUNNING, INC.



(BSP03)

BALTIMORE, MARYLAND 21201



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Medical Factors in Outpatient Dental Anesthesia , Richard M. Herd, D.D.S., J. Thayer Waldo, M.D., D.D.S., Indianapolis	1345
Paramecia Reveal Basic Cellular Physiology , Jo Anne Mueller, Evansville	1348
Congenital Rubella Syndrome: Experience with 13 Cases , Eric L. Effmann, A.B., New Haven, Conn., Gerald L. Kurlander, M.D., Indianapolis	1350
Mediastinoscopy — A Safe, Practical Technic , Harry Siderys, M.D., John N. Pittman, M.D., Indianapolis	1359
Pregnancy Complicated by Pseudohemophilia (Von-Willebrand's Disease) , Robert E. McCammon, M.D., Homestead AFB, Fla.	1363
Electrocardiogram of the Month: Double Tachycardia in Emphysema , Charles Fisch, M.D., Indianapolis	1371
X-Ray Conference: Superimposition Cystography , Erich K. Lang, M.D., Indianapolis ..	1372
The Cancer You View , Paul V. Evans, M.D., Laurence H. Bates, M.D., Indianapolis ..	1374
Fractures and Orthopedic Problems: Flat Feet, Plantar Warts and Corns , John A. Crawford, M.D., Indianapolis	1376
Path-finder: Serum Enzymes and Myocardial Infarction , W. P. Loh, M.D., Gary ...	1381

EDITORIALS

Clinical Investigation: Why Make It More Difficult?	1384
Generic Equivalents (Guest)	1384
The Price of People: Crucial Quantity in Hospital Costs (Guest)	1386
21st Clinical Convention of the AMA (Guest)	1388
Editorial Notes	1388

SPECIAL FEATURES

Meet The Journal Staff	1390
The Passing of the Doctor , George S. Bond, M.D., Indianapolis	1401

REGULAR FEATURES

Month in Washington	1326
What's New?	1339
Fourth Estate	1340
President's Page	1391
The Woman's Auxiliary Reports to ISMA	1392
Blue Shield and Blue Cross Again Return Most in Benefits , (One of a Series)	1408
News from Indiana University School of Medicine	1415
Medicine At Law	1420
Wanted: Locations, Physicians	1427
Annual Meeting Dates of Professional Medical and Allied Organizations	1435
Board of Health Report	1438
Abstracts, Book Reviews	1439
From The Journal 50 Years Ago	1444
News Notes	1451
Future Meetings, Seminars, Courses	1455
County, District News	1457

BUSINESS

Executive Committee: Aug. 12, 1967	1458
The Council: July 30, 1967	1459

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Romsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared far o specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Paplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 1354.



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet dis-

integration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545
ANNUAL CONVENTION—OCTOBER 9-12, 1967—INDIANAPOLIS

OFFICERS FOR 1967-68

President—Eugene S. Rifner, M.D., Van Buren 46991.

President-Elect—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

Treasurer—Ottis N. Olvey, M.D., 3231 N. Meridian, #11, Indianapolis 46208.

Assistant Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scottsburg 47170.

Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian Indianapolis 46208.

Legal Counselor—Mr. Robert Hallowell, 1440 Consolidated Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian Indianapolis 46208.

COUNCILORS

District	Term Expires
1—P. J. V. Corcoran, Evansville.....	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Keri, Bedford	Oct. 1967
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—William R. Tindall, Shelbyville	Oct. 1967
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1967
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—Milton F. Papp, Fort Wayne	Oct. 1967
13—Otis R. Bawen, Bremen	Oct. 1968

SECTION OFFICERS 1967-68

Section on Surgery:

Chairman—Joseph C. Finneran, Indianapolis
Vice-chairman—Donald M. Schlegel, Indianapolis
Secretary—Henry Larzelere, Marian

Section on Internal Medicine:

Chairman—Charles M. Sinn, Evansville
Vice-chairman—Lavis Sandack, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—M. Richard Harding, Indianapolis
Vice-chairman—David E. Brown, Indianapolis
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—Eugene Schmidt, Fort Wayne
Vice-chairman—William M. Matthews, Indianapolis
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Ross Egger, Middletown
Vice-chairman—Jay S. Reese, Martinsville
Secretary—Robert Mauser, Indianapolis

Section on Obstetrics and Gynecology:

Chairman—Joseph F. Thompson, Indianapolis
Vice-chairman—Robert M. Reid, Columbus
Secretary—Tom W. Wachab, Jr., Kokomo

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Richard A. Silver, Indianapolis
Vice-chairman—John A. Robb, Indianapolis
Secretary—Edwin F. Kach, Jr., Muncie

Section on Nervous and Mental Diseases:

Chairman—Donald F. Moore, Indianapolis
Vice-chairman—Hans Meyer, Westville
Secretary—Gene E. Lynn, Indianapolis

Section on Pathology:

Chairman—Joseph L. Haymond, Indianapolis
Vice-chairman—Robert J. Frost, Michigan City
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Roland E. Miller, Lafayette
Vice-chairman—Wendell E. Brown, Indianapolis
Secretary—Marris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1967:

Delegates

Guy A. Owsley
Hartford City

Jack E. Shields
Browns town

Alternates

Maurice E. Glock
Fort Wayne

Dwight W. Schuster
Indianapolis

Terms expire December 31, 1968:

Delegates

Harald C. Ochsner
Indianapolis

Eugene F. Senseny
Fort Wayne

Frank H. Green
Rushville

Alternates

James H. Gasman
Indianapolis

Robert M. Brown
Marion

Kenneth O. Neumann,
Lafayette

ACID & AIR

DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.

ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; Eugene S. Rifner, Van Buren, President; G. O. Larson, LaPorte, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Ottis N. Olvey, Indianapolis, Treasurer; Lester H. Hoyt, Indianapolis, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Glock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis, secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salom, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Gootee, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Glock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholtz, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hovda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finfrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Okla W. Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Anderson; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert C. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseny, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordsville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salom, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammond; Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry C. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veedsburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donalo M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordsville.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowe H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Hobgood, Evansville	
2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Doniel H. Cannon, New Albany	Elmer L. Walloce, New Albany	
4.	Frank B. Bard, Crothersville	Horold E. Miller, Seymour	
5.	Thomas J. Conway, Terre Haute	Arnold W. Kunkler, Terre Haute	
6.	Paul Inlow, Shelbyville	Perry Seol, Brookville	
7.	Jay Reese, Martinsville	James H. Gosman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	
9.	Harry T. Stout, Frankfort	Harry K. Williams, Frankfort	
10.	R. James Bills, Gory	John J. Reed, Hobart	
11.	Charles Wise, Comden	Fred Poehler, La Fontaine	
12.	Max M. Gilin, Bluffton	Berniece Williams, Fort Wayne	
13.	Gordon Cook, South Bend	John Hildebrand, South Bend	



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?
in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function. Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately 25 mg. per pound of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. 250 mg. for children, available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy — 1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

NegGram®
Brand of
nalidixic acid
a specific anti-gram-negative

eradicates most urinary
tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.

- "Excellent" or "good" response reported in more than 2 out of 3 patients with either chronic or acute gram-negative infections.¹

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: E. coli, Klebsiella, Aerobacter, Proteus, Paracolon or Pseudomonas²... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubeis
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe

Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Griffith Marr, Columbus
A. L. Coddens, Earl Park
Robert H. Wiseheart, Lebanon
Don J. Wagoner, Delphi
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
I. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazev, Washington
Alfred K. Rhodes, Lawrenceburg
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
James Y. McCullough, New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waitt, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
James S. McElroy, New Castle
Donald Fields, Kokomo
Barth E. Wheeler, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisett, Madison
George Brown, Greenwood

Boyd K. Black, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford
Robert D. Williams, Anderson
Dwight W. Schuster, Indianapolis

John K. Guild, Plymouth
Parker W. Snyder, Peru
V. G. Viray, Crawfordsville
Ellery T. Drake, Martinsville
John Parker, Goodland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington

John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Clackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Philip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
H. H. Dunham, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David G. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave.,
Fort Wayne
Mr. Larry L. Pickering, Exec. Secy.,
212 Med. Ctr. Bldg., Fort Wayne
Donald L. Sandlin, 2530 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
James R. McAfee, 1005 N. East, Lebanon
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street,
Logansport
Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St.,
Frankfort
C. Philip Fox, 305 Peoples Bank, Washington
J. Kenneth Jackson, 223 Mechanic St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntington
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman
Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert G. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren
William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St.,
Franklin
John S. Murray, 317 Security Bank Bldg.,
Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave.,
Gary
Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave.,
LaPorte
Joseph D. McPike, 1714 24th St., Bedford
William M. Stimson, 333 Jackson St., Anderson
John O. Butler, 234 E. Southern Ave.,
Indianapolis
Mr. Arthur G. Loftin, Exec. Secy., 2902 N.
Meridian, Indianapolis
M. George Rosero, 921 Lake Shore Dr., Culver
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 101½ N. Main St., Martinsville
Arthur Schoonveld, Brook
Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Kermit Q. Hibner, 117 N. Grant St.,
Bloomington
Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital,
Valparaiso
Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe,
South Bend
Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tierman, Exec. Secy., 109½ S. E.
3rd., Evansville
Robert L. Meissel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea

problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas
Donnagel® -PG (Donnagel with paregoric equivalent).

Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN®



THERE'S A
FORMULATION
FOR EVERY
COUGHING NEED

All the Robitussins contain glyceryl
guaiacolate, the outstanding expectorant agent
that greatly increases the output of lower
respiratory tract fluid. Increased RTF volume
exerts a demulcent effect on the
tracheo-bronchial mucosa, promotes ciliary
action, and makes thick, inspissated mucus
less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Pheniramine maleate 7.5 mg.
Codeine phosphate 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Dextromethorphan hydrobromide . . 15.0 mg.
Alcohol, 1.4%

New! Clears sinuses and nasal
stuffiness as it relieves cough
ROBITUSSIN®-PE
Each 5 cc. contains:
Glyceryl guaiacolate 100 mg.
Phenylephrine hydrochloride . . . 10.0 mg.
Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTI-HISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The American Medical Association strongly opposed a suggestion that doctors' fees under Medicare be based on Blue Shield schedules.

THE SUGGESTION was made to AMA officials while they were testifying before the Senate Finance Committee on the House-approved Social Security bill which includes amendments to the Medicare and Medicaid programs. Dr. Samuel R. Sherman, San Francisco, chairman of the AMA's Council on Legislative Activities, said there would be heavy opposition from the medical profession to any change from the present usual-and-customary fees.

DR. MILFORD O. ROUSE, president of the AMA, gave general approval to the bill passed by the House which, he points out, incorporated a number of changes recommended by the AMA. He said further substantive changes better could await the knowledge that one or two more years of experience would bring. However, he urged that consideration then be given to major changes in Medicare Plan B which covers physicians' services.

"WE BELIEVE it is possible for the Congress, the medical profession and others interested in the subject to develop a new mechanism for delivering medical care to people over 65 that would be consistent with existing private sector mechanisms," Dr. Rouse said.

". . . THE CONGRESS realizes it has an open-end program with rising and perhaps uncontrollable costs. We believe that it is possible, and would be eminently practical, to devise another approach that could solve problems which beset Part B. One possibility, for example, might be to substitute for the Part B program a subsidy to all eligible persons, to be used for the purchase of private health insurance. Such an approach could have many advantages.

"THE ELIGIBLE over-65 patient would have a qualified private insurance program of his choice, at no greater expense than he has under the Part B Medicare program; carriers would have a greater responsibility for their own performance with an opportunity to exercise initiative; the physician would continue to deal with his over-65 patient in every respect in the same way as he did before the patient's birthday; and the Congress would have a program with defined costs, and one which would offer the nation a comparison of mechanisms in use to meet the problems of financing health care of the elderly."

OTHER POINTS in the AMA testimony included:

- BEGINNING with the provisions of Title XVIII (Medicare), the (House) bill does not place the disabled of all ages under Medicare, as has been proposed earlier. We think the House acted wisely in establishing instead, a special Advisory Council to study the problems related to the inclusion of this group and to study the costs involved.
- IN ADDITION to the present method of payment for physician's services, the (House) bill provides two new options: either the physician can submit his itemized bill directly to the carrier, in which case payment of 80% of the reasonable charge would be made to him, providing the full charges does not exceed the reasonable charge, or to the patient at his direction; or the patient may submit the itemized bill and be paid 80% of the reasonable charge. From the program's inception, the AMA has urged that the payment be permitted on the basis of an itemized statement of charges.
- OUTPATIENT hospital diagnostic services would be transferred to Part B of Title XVIII and be subject to the deductible and coinsurance features. This is in keeping with our recommendation to the House Ways and Means Committee that outpatient services be included under Part B, and so remove the administrative difficulty of distinguishing between therapeutic and diagnostic services.
- THE BILL ELIMINATES both the requirement for initial physician certification for hospitalization of Medicare patients and the requirement for physician certification for outpatient hospital services. The AMA recommended the elimination of initial certification and the subsequent recertification. We continue to recommend the addition of this second step to eliminate the requirement of any certification, since any need in this regard will be satisfied by the work of the medical review or utilization review committee.
- WE BELIEVE that physicians, having been brought under Social Security, should be accorded the same privilege and opportunity for reaching a fully insured status as was accorded other professional groups when they were included in the program. Accordingly, we urge this committee to consider the adoption for physicians of an "alternative insured status" similar to that permitted by the amendments of 1954 and 1956 which brought into the program many new groups of people and professional self-employed persons, including lawyers. Further, we urge this committee to consider amendments that would "drop out" an appropriate number of years for physicians to make their eligibility for cash benefits both equitable and realistic.
- WE MUST OPPOSE the drug legislation offered before this committee as amendments to H. R. 12080. We would suggest that rather than to enact such legislation it would be worthwhile at this time to study in depth, all the economic and therapeutic factors which enter into the use of prescription drugs.

NEW EFFORTS IN CAMPAIGN AGAINST SMOKING

THE FEDERAL GOVERNMENT has stepped up its campaign against cigarette smoking with the

issuance of a new report and the appointment of a Lung Cancer Task Force.

A SECOND Public Health Service report on the subject summarizes three and one-half years of research and study into the health dangers of smoking. The Department of Health, Education and Welfare said the report confirms and strengthens the conclusions of a 1964 report. The second report provides new technical data on the relationship of smoking to cardiovascular, chronic bronchopulmonary disease, cancer and other conditions.

—CIGARETTE SMOKERS have substantially higher rates of death and disability than their nonsmoking counterparts in the population. This means that cigarette smokers tend to die at earlier ages and experience more days of disability than comparable non-smokers.

—A SUBSTANTIAL portion of earlier deaths and excess disability would not have occurred if those affected had never smoked.

—IF IT WERE NOT for cigarette smoking, practically none of the earlier deaths from lung cancer would have occurred; nor a substantial portion of the earlier deaths from chronic bronchopulmonary diseases (commonly diagnosed as chronic bronchitis or pulmonary emphysema or both); nor a portion of the earlier deaths of cardiovascular origin. Excess disability from chronic pulmonary and cardiovascular diseases would also be less.

—CESSATION or appreciable reduction of cigarette smoking could delay or avert a substantial portion of deaths which occur from lung cancer, a substantial portion of the earlier deaths and excess disability from chronic bronchopulmonary diseases, and a portion of the earlier deaths and excess disability of cardiovascular origin.

DR. KENNETH M. ENDICOTT, director of the National Cancer Institute, is chairman of the Lung Cancer Task Force made up of 10 physicians and scientists.

DR. ENDICOTT said that the group will concentrate on research for the development of a less hazardous cigarette, prevention of occupational cancer due to exposure of workers to cancer-causing substances in their working environment, and improvement of the present low lung cancer cure rate of five percent.



New view of an oral contraceptive at work

Although suppression of ovulation remains the primary mode of action of oral contraceptives, newer knowledge indicates that products like Norinyl-1—a combination of both low-dosage progestogen and estrogen for the full treatment cycle—may provide multiple action that helps explain their unexcelled record of contraceptive effectiveness. This report explores the possible secondary protective mechanisms offered by combined hormonal administration.

Accumulating evidence has indicated that sparse, highly viscous cervical mucus has a possible adverse effect on the motility and survival of spermatozoa.

The estrogen-opposing progestational ingredient of Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.) changes the usual mid-cycle picture of a thin, watery cervical mucus. The result—a built-in barrier that appears to inhibit sperm from reaching the ovum should one be released. The inset in the adjoining photograph shows immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How the estrogen-opposing action of Norinyl-1 creates cervical mucus that may be hostile to sperm penetration

Normally, estrogen activity during the fertile midcycle stimulates the production of a profuse and watery cervical mucus that permits maximum sperm motility and promotes penetration.

But what happens when Norinyl-1 is administered? Its potent progestogen, norethindrone, opposes estrogen stimulation of cervical mucus. Consequently, the amount of mucus decreases and its viscosity increases. This results in a sparse but thick mucus barrier that appears to diminish the vitality of the sperm and to impair its powers of penetration.

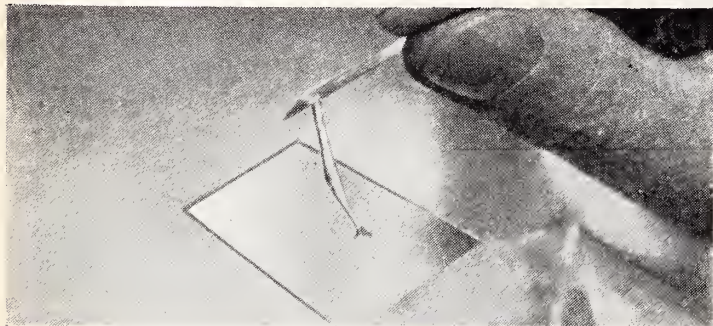
The role of viscous cervical mucus as a secondary action of Norinyl-1

In a report on 89 patients taking this medication,* cervical mucus obtained from cycle day 5 to cycle day 29 appeared scant and thick and exhibited little or no Spinnbarkeit.

In the opinion of this investigator, the effect on cervical mucus may be sufficient to prevent conception.

*Cohen, M. R.: Symposium: Mechanisms of Action of Low Dosage Oral Contraceptive, Yale University Medical Center, New Haven, Conn., April 6, 1967.

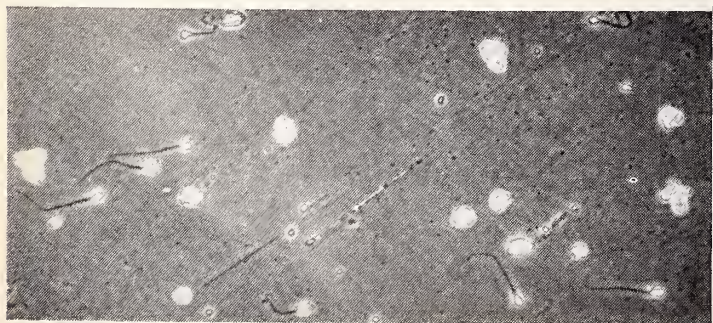
Normal cervical mucus at midcycle in untreated patient is known to permit sperm motility... promote sperm penetration.



Cervical mucus is thin and watery with a stretchability (Spinnbarkeit) of 15 to 20 cm.

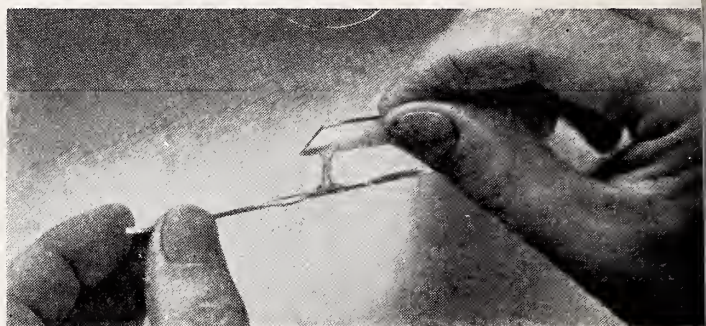


Thin, watery mucus crystallizes into this well-defined, fernlike pattern within a minute.

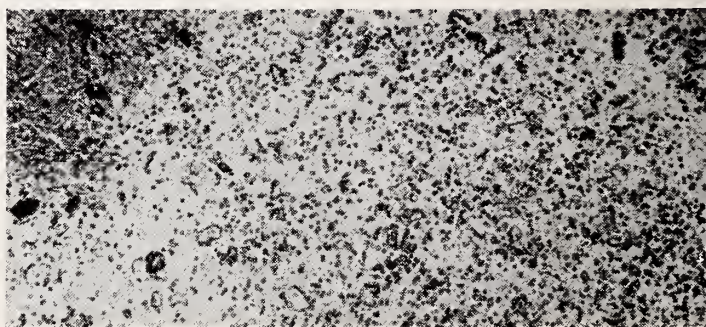


Spermatozoa appear healthy, are active and freemoving.

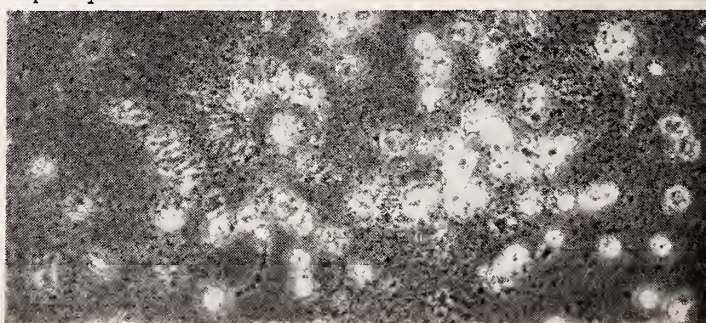
Viscous cervical mucus at midcycle produced by Norinyl-1 appears to impair sperm vitality... inhibit penetration.



Cervical mucus is scanty, thick and viscous. Spinnbarkeit is 1 cm. or less.



In thick, viscous cervical mucus the fern pattern is poorly defined or absent.

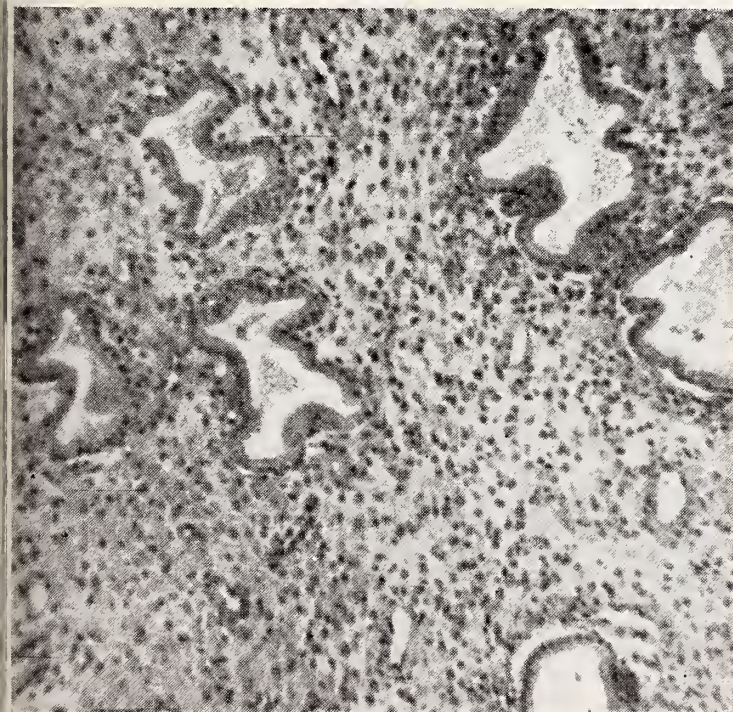


Immobile spermatozoa as they appear in cervical mucus taken from a patient treated with Norinyl-1.

How Norinyl-1 alters normal endometrial responses— another possible protective mechanism

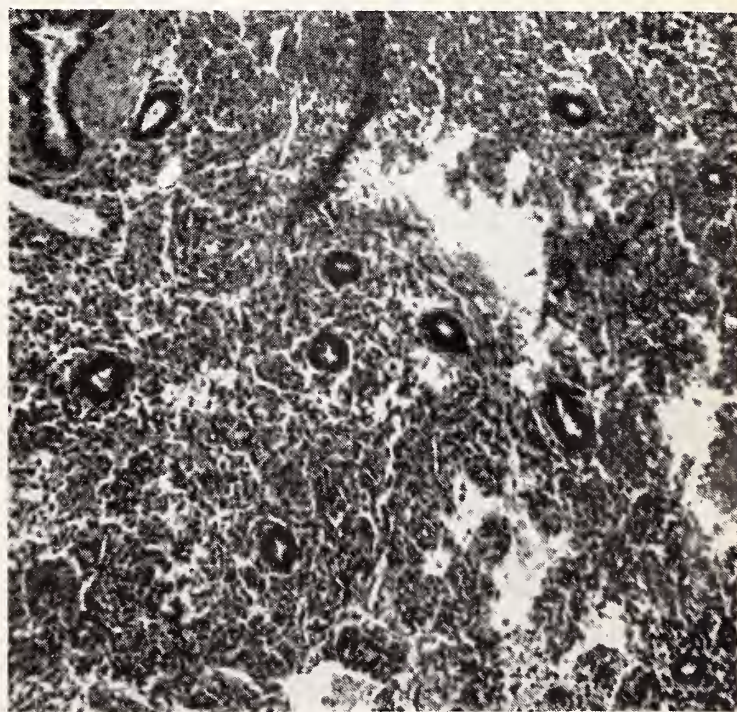
Let us suppose that an ovum is released—as occurs in an occasional, rare case—and somehow a sperm succeeds in penetrating the cervical mucus barrier. Should this come about, one additional action of Norinyl-1 may protect the patient from unwanted pregnancy. The theory is that progestogen intake makes endometrial tissue unreceptive to implantation.

Endometrium of
untreated patient



Normally, the endometrium progresses through a proliferative phase stimulated by estrogen and a secretory phase stimulated by progesterone. During the secretory phase the endometrium is receptive to the fertilized ovum.

Endometrium produced
by Norinyl-1



When Norinyl-1 is administered its progestogen component—norethindrone—accelerates the secretory phase and suppresses glandular and vascular development.

new
Norinyl-1
(norethindrone 1mg, ♂ mestranol 0.05mg) **tablets**

effective fertility control
on half the previous dosage

maintains ratio
of the established
norethindrone/mestranol
combination

lower cost

new Norinyl-1[®] (norethindrone 1mg. \bar{c} mestranol 0.05mg.) tablets

Reduction of oral contraceptive dosage to lowest effective levels has become a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now available in a new strength in which both norethindrone and mestranol are reduced 50 percent. Studies show that Norinyl-1 achieves fertility control with only 1.0 mg. of combined progestogen and estrogen per tablet.

Norethindrone was first reported for use as a progestational agent in human beings in 1955. Norethindrone 2 mg. with mestranol 0.1 mg., as an oral contraceptive, is currently in use by over 2,000,000 women. Clinical experience now establishes that Norinyl-1 also amply meets the criteria of reliability and safety.*

*Symposium on Low-Dosage Oral Contraception, Palo Alto, Calif., July 15, 1965.

PRESCRIBING INFORMATION

Contraindications: 1. Patients with thrombophlebitis or with a history of thrombophlebitis or pulmonary embolism. 2. Liver dysfunction or disease. 3. Patients with known or suspected carcinoma of the breast or genital organs. 4. Undiagnosed vaginal bleeding.

Warnings: 1. Discontinue medication pending examination if there is sudden partial or complete loss of vision or if there is a sudden onset of proptosis, diplopia, or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. 2. Since the safety of Norinyl-1 in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period. 3. Detectable amounts of the active ingredients in oral contraceptives have been identified in the milk of mothers receiving these drugs. The significance of this dose to the infant has not been determined.

Precautions: 1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear. 2. Endocrine and possibly liver function tests may be affected by treatment with Norinyl-1. Therefore, if such tests are abnormal in a patient taking Norinyl-1, it is recommended that they be repeated after the drug has been withdrawn for 2 months. 3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibroids may increase in size. 4. Because these agents may cause some degree of fluid retention, conditions that may be influenced by this factor, such as epilepsy, migraine, asthma, cardiac, or renal dysfunction, require careful observation. 5. Although a cause and effect relationship has not been established, Norinyl-1 should be used with caution in patients with a history of cerebrovascular accident. 6. In relation to breakthrough bleeding, as in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are

indicated. 7. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree. 8. Any possible influence of prolonged Norinyl-1 therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study. 9. A decrease in glucose tolerance has been observed in a small percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving Norinyl-1 therapy. 10. Because of the occasional occurrence of thrombophlebitis and pulmonary embolism in patients taking oral contraceptives, the physician should be alert to the earliest manifestations of the disease. A cause and effect relationship has not been demonstrated. 11. Because of the effects of estrogens on epiphyseal closure, Norinyl-1 should be used judiciously in young patients in whom bone growth is not complete. 12. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask the onset of the climacteric. 13. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following adverse reactions have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma, breast changes (tenderness, enlargement and secretion), loss of scalp hair, change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, erythema multiforme, erythema nodosum, hemorrhagic eruption, migraine, rash (allergic), itching, rise in blood pressure in susceptible individuals, mental depression.

The following occurrences have been observed in users of oral contraceptives. A cause and effect relationship has not been established: thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory results may be

altered by the use of oral contraceptives: increased bromsulphalein retention and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and but not extractable protein-bound iodine and decrease in T³ values), metapyrone test, pregnandiol determination.

Other side effects reported to have occurred in association with use of this drug are dizziness, hirsutism, pains in legs, back, chest and abdomen, dysuria, drowsiness, vaginal discharge, libido increased and decreased, eruptions, hypermenorrhea, hypomenorrhea, increased appetite, G.U. infections, varicose veins, abdominal fullness, acne, headache, nervousness, allergies, blurred vision, pain in eyes, and itching in eyes. For complete clinical data, see package insert.

Dosage and Administration: 1. One tablet of Norinyl-1 is administered orally for 20 days beginning on day 5 of the menstrual cycle (Count day 1 of the cycle as the first day of menstrual bleeding.) Repeat this dosage schedule for each cycle. 2. If no menstrual period occurs after a cycle of treatment (20 tablets) in which patient adhered to the schedule, the patient must be instructed to resume taking the Norinyl-1 tablets 7 days after the previous 20 day course was completed. For example, if the last pill of a previous cycle had been taken on a Sunday, then a new cycle of treatment should begin on the following Sunday. 3. In the postpartum woman, it is recommended that the first cycle of treatment should begin on day 1 of the first menstrual cycle. However, Norinyl-1 should not be administered during lactation.

Availability: Norinyl-1 (norethindrone 1 mg. with mestranol 0.05 mg.).—Dispensers of 20 and 60 and bottles of 250 tablets.

norethindrone — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

A Building Block approach to treating hypertension



With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Eutonyl affords a different kind of basic therapy for moderate to severe cases



Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.^{1,2}

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.





Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
				
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

Eutron adds thiazide for enhanced therapy with milder side effects



Only a 7/4 mm. span between standing and recumbent pressures in clinical trials—reduced chance of orthostatic hypotension

The combining of Eutonyl and Enduron in Eutron permits a significantly greater antihypertensive effect than with either agent used alone. This in turn may allow therapeutic success with lesser dosage—and correspondingly milder side effects.

A significant finding in clinical trials was the drug's action in lowering blood pressure to *nearly equal levels in all body positions*. Total average spread between standing and recumbent readings (after treatment) was only 7/4 mm. Hg.

Thus, in your moderate to severe cases, Eutron affords a usually smooth course of therapy, often with reduced likelihood of orthostatic effects. (The usual precautions against rising suddenly, of course, will always apply.) And, because of the thiazide component, Eutron may be used in the presence of congestive heart failure.

Once a day, every day

EUTRON™
PARGYLINE HYDROCHLORIDE 25 MG.
WITH METHYCHLOTHIAZIDE 5 MG.



DAILY DOSAGE RANGE

Minimum



12.5 mg. pargyline hydrochloride and 2.5 mg. methyclothiazide

Usual starting



25 mg. pargyline hydrochloride and 5 mg. methyclothiazide

Intermediate



37.5 mg. pargyline hydrochloride and 7.5 mg. methyclothiazide

Maximum



50 mg. pargyline hydrochloride and 10 mg. methyclothiazide

ENDURON® ENDURONYL®

METHYLCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Enduron is used to control edema and mild to moderate hypertension; also used with other drugs for hypertension. Enduronyl is used in mild to moderately severe hypertension; when used with Enduronyl, more potent agents can be given at reduced dosage to minimize undesirable side effects.

Contraindications: Neither Enduron nor Enduronyl should be used in severe renal disease (except nephrosis) or shutdown; in severe hepatic disease or impending hepatic coma; in patients sensitive to thiazides. Hepatic coma has been reported as a result of hypokalemia in patients receiving thiazides.

Enduronyl is contraindicated in patients with severe mental depression and suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity reactions in patients with a history of allergy or asthma. If added potassium intake is indicated, dietary supplementation is recommended. Enteric-coated potassium tablets should be reserved for cautious use only when adequate dietary supplementation is not practical because those tablets may induce serious or fatal small bowel lesions consisting of stenosis with or without ulceration. These small bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs.

Precautions: Use thiazides with caution in severe renal dysfunction, impaired hepatic function, or progressive liver disease. In surgical patients, thiazides may reduce the response to vasopressors and increase the response to tubocurarine. Use thiazides with caution in pregnancy (bone marrow depression, thrombocytopenia, or altered carbohydrate metabolism have been reported in certain newborn infants). Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. Antihypertensive response may be enhanced following sympathectomy.

Use Enduronyl with caution in patients with a history of peptic ulcer, as rauwolfias may increase gastric secretion. Discontinue at the first sign of mental depression. Rauwolfia alkaloids may increase hypotensive effects of surgery or anesthesia, and should be discontinued two weeks prior. They also lower the convulsive threshold and shorten seizure latency. In epilepsy, dosage adjustment of anticonvulsant medication may be necessary. Alcohol, barbiturates, or narcotics may potentiate action of deserpidine.

Adverse Reactions: During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). All patients should be observed for signs of hyponatremia ("low-salt" syndrome). Reported thiazide reactions include: anorexia, nausea, vomiting, diarrhea, headache, skin rash, dizziness, paresthesia, weakness, photosensitivity, jaundice, and pancreatitis.

Reported rauwolfia reactions include: nasal stuffiness, nausea, weight gain, diarrhea, aggravation of peptic ulcer, epistaxis, skin eruption, and reduction of libido and potency. Excessive drowsiness, fatigue, weakness, and nightmares may signal early signs of mental depression.

EUTONYL® EUTRON™

PARGYLINE HYDROCHLORIDE

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications: For treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. Not recommended for patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone. It is desirable to establish the dosage of Eutron by administering component drugs separately.

Contraindications: Pheochromocytoma, advanced renal disease, increasing renal dysfunction, paranoid schizophrenia and hyperthyroidism. Hepatic coma has been reported as consequence of hypokalemia with thiazide therapy. Until further experience is gained not recommended for patients with malignant hypertension, children under 12, or pregnant patients.

Concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. 2 week interval should separate therapy and use of these agents.

Methyclothiazide is contraindicated in patients with known sensitivity to thiazides.

Warnings: Pargyline hydrochloride is a monoamine oxidase inhibitor. Warn patients against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When indicated, alcohol, narcotics (meperidine should be avoided), antihistamines, barbiturates, chloral hydrate, and other hypnotics, sedatives, tranquilizers, or caffeine, may be used cautiously in reduced dosage. In emergency surgery 1/4 to 1/2 the usual dose of narcotics, analgesics, and other premedications should be used avoiding parenteral administration where possible. Carefully adjust dose of anesthetics to response of patient. Withdraw pargyline two weeks before elective surgery.

Warn patients about the possibility of postural hypotension. Those with angina or coronary artery disease should not increase physical activity with an improvement in well being. Pargyline may lower blood sugar.

Avoid use of enteric-coated potassium tablets, as these may induce serious or fatal small-bowel lesions consisting of stenosis with or without ulceration. These small-bowel lesions have caused obstruction, hemorrhage and perforation frequently requiring surgery. Medication should be discontinued immediately if abdominal pain, distension, nausea, vomiting or GI bleeding occurs. These products contain no added potassium salts and if added potassium intake is desired, dietary supplementation is recommended. Coated potassium tablets should be reserved for cautious use when adequate dietary supplementation is impractical. In patients with a history of allergy or asthma the possibility of sensitivity reactions should be considered.

Precautions: Measure blood pressure while patient is standing to determine antihypertensive effect. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Use with caution in patients with liver disease. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. With prolonged therapy, examine patients for change in color perception, visual fields and fundi. Also reported have been: blood dyscrasias including thrombocytopenia with purpura, agranulocytosis and aplastic anemia; elevations of BUN, serum uric acid, or blood sugar. Symptomatic gout may be induced. In surgical patients thiazides may reduce response to vasopressors and increase response to tubocurarine.

Adverse Reactions: Pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extrapyramidal symptoms have been reported in a few patients with reduced cardiac reserve.

During intensive or prolonged therapy, guard against hypochloremic alkalosis and hypokalemia (especially the latter if patient is on digitalis). Observe all patients for signs of hyponatremia ("low salt" syndrome).

Reported thiazide reactions also include anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, and pancreatitis. Nocturia has been observed with the combination.

709075R



What's New?

NASA periodically releases details of innovations derived from the space program which may be of commercial or civilian use. A recent release concerns an adjustable metal hinge which may be incorporated in a leg cast in such a way as to allow elective amounts of knee flexion or may be locked into an immovable position. Inquiries may be directed to the Technology Utilization Officer, Marshall Space Flight Center, Huntsville, Alabama 35812.

Parke Davis has obtained final clearance from the FDA to market a one-milligram version of Norlestrin. The one-mg tablet will be supplied in bottles of 100, and in dispensing packages of five 20-tablet folders, each folder representing a month's supply. Norlestrin also will continue to be available in the 2.5 mg strength.

* * *

Wholesale prices for quinine and quinidine in 1966 were five or six times as much as in 1964. Prices for formulations of quinine, quinidine and colchicine were raised naturally, but not in as high a proportion. Eli Lilly now announces price reductions in formulation of from ten to 16%. Price decline is based on the expectation of lower and more stable costs for raw materials in the future.

* * *

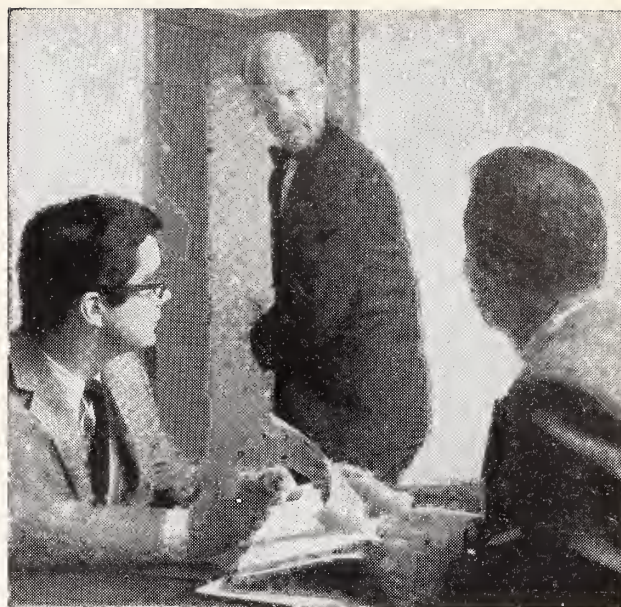
Professional Disposable Products, Inc., Mount Vernon, New York, has added a new corporate division to market disposable products especially designed for home convalescent patients. The home-use items will include disposable incontinent pads, personal rubber urinals, colostomy appliances and emergency oxygen kits.

* * *

A new reference control for hemoglobin determinations, trademarked Globintrol, has been introduced by the Pfizer diagnostics department of Chas. Pfizer & Co. Globintrol is analogous to Celltrol reference control for red blood cell counts and hematocrits and Leukotrol (reference controls for white blood cell counts). Together, these products offer the first complete quality control system for the hematology laboratory.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



He leaves to make an urgent call But doesn't use the phone at all

Parepectolin for quick relief of acute diarrhea
...soothes colicky pain with paregoric
...consolidates fluid stools with pectin
...adsorbs irritants with kaolin, and protects
intestinal mucosa.

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.

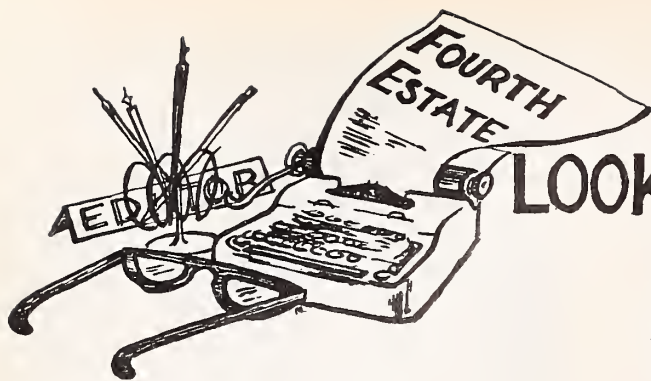


Parepectolin®

Each fluid ounce of creamy white suspension contains:
Paregoric (equivalent)..... (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid
ounce.
warning: may be habit forming
Pectin (2½ grains) 162 mg.
Kaolin (specially purified).... (85 grains) 5.5 Gm.
(alcohol 0.69%)
Usual Adult Dose: One or two tablespoonfuls three
times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Looks to Future

No single group of citizens is more directly responsible for the health of the people of the United States than the members of the medical profession. They are the ones who are on the front lines literally in an emergency, whether it be a natural catastrophe or an epidemic of measles.

Medical men working in scores and hundreds of activities relating to medical matters involving health are thinking and studying years in the future. A typical example of their work was the American Medical Association sponsored Congress on Environmental Health Problems which was held in New York City.

In the language of an AMA announcement pamphlet, "Managing the diverse and complex systems of our physical environment to protect and promote the health of our growing population is the responsibility of all society. This fourth in a series of AMA sponsored Congresses on Environmental Health Problems will explore concepts, functions and responsibilities involved in the development of integrated research programs and the full utilization and effective coordination of our professional, administrative, and technological resources"

Speakers at the Congress covered a wide range of subjects dealing with the problems of modern life. Included were discussions on such things as tension, air pollution, water supply, adequate health care facilities and the role various bodies, including industry, must play in preserving a liveable

world in the years to come.

And, the devotion of the medical profession today to the problems of tomorrow will in large part determine what that world is to be like.—*Edinburg Courier*, July 6, 1967.

The AMA On Marijuana

Fears that the use of marijuana may be spreading among high school students have been given new impetus by the American Medical Association's Committee on Alcoholism and Drug Dependence. Though it offers little hard data in support of such fears, the committee's statement is of importance because it brings into sharper focus a subject about which so much has been said and written of late.

The doctors' panel, for example, places in better perspective the question of just how harmful marijuana may be. While noting that no lasting mental or physical changes as the result of using it have yet been demonstrated, the committee stresses that its use has psychiatric implications.

Thus, though the drug is not physically habit-forming, "persons who use marijuana continually and as a symptomatic expression of psychological conflict, a means of gaining social acceptance, or a way of escaping painful experiences of anxiety or depression may be said to be psychologically dependent on the substance." The panel relates this to adolescents' tendency "to seek new and exciting experiences, to question self, family and society, to try on and discard new guises of behavior to reconcile opposing pulls and strains. . . ."

Whether or not the use of marijuana is spreading among teen-agers, it poses serious questions for parents, educators and others wherever it is used. And the AMA committee's statement bolsters the view that this is essentially a psychological and sociological problem. It must be dealt with as such. We cannot depend merely on enforcement of punitive laws which in many cases spring from fear and ignorance rather than from understanding of what is involved. —*Terre Haute Tribune*, Aug. 19, 1967.

New Medical Education Program

The citizens of Fort Wayne are deeply interested in the selection of their city as the location of the initial phase of an Indiana University plan for the future development of medical education in the state.

The new program will permit medical students to take clinical work here.

It will be under the joint sponsorship of the Fort Wayne Medical Society, the Lutheran, Parkview and St. Joseph's hospitals and the Indiana University School of Medicine.

Dr. Franklin A. Bryan, recently appointed medical education director of the Fort Wayne Medical Society Education Foundation will be the director of the new program here.

It is designed to use local facilities and physicians to create cooperative programs on the undergraduate level, internships, residencies and continuing education for practicing physicians.

The program will be staffed largely

by local doctors and there will be television and telephone hookups with the Indiana University School of Medicine in Indianapolis.

The teaching program for internal medicine already has been approved by the university and will begin in September at the local hospitals.

This program will create a vigorous interest in the medical profession here. It is also expected to encourage doctors educated in Indiana to remain in the state to practice their profession.

There has been considerable concern in recent years that so many doctors who went to medical school in Indiana moved to other states to practice.

There is much pioneering spirit in education today and, of course, this spirit must be encouraged and continued.

Education should be brought ever nearer to the people.

The new program is a good step in that direction.—*Fort Wayne Journal-Gazette*, Aug. 25, 1967.

More Beds Needed

If Bedford's addition to Dunn Memorial Hospital was already completed, and if the proposed new Atomedic Hospital on West Sixteenth Street was already in existence, hospital facilities in Bedford would need to be increased by 50% to provide the population of this area with adequate facilities.

That statement is based on reports of local doctors and a report by the State Board of Health which said recently that Indiana will need 3,000 more regular hospital beds, and about that many long-term care beds within the next five years.

It is estimated that Bedford serves a total of 75,000 to 100,000 persons in southern Indiana. Hospital needs amount to five beds per 1,000 population. If we take the minimum figure of 75,000 population, the need exists for 375 hospital beds.

Bedford now has about 100 beds. Thirty-two beds will be added to

facilities of Dunn Memorial Hospital when the present proposed expansion program is completed, and the proposed new Atomedic Hospital will have 117 beds. That comes to a grand total of 249 beds — 126 short of the total needed for the area's population.

At present, a lot of local people are getting medical and hospital service out of town, primarily because facilities do not exist locally. A local doctor said that certain of our physicians have diagnostic and treatment capabilities which they cannot perform because of lack of facilities in Dunn Hospital. Hospital projects now in the planning stages will close many of those gaps.

It was also brought out by our informant that a city which has inadequate hospital facilities will not attract new doctors, and that hospital facilities are the first thing a prospective new doctor looks at when considering locating in a particular city.

The Dunn Memorial addition is approaching the starting point, and developments are expected regarding the new Atomedic Hospital within the next month. So there is hope that the shortage of hospital beds will be relieved within a year or so.

The projected need for hospital beds, however, does not include the need for nursing home beds and this is another matter. As it is, hospitals get many people who need to be in nursing homes, and beds are thus denied for persons needing medical or surgical services.

There is no question that there is room in Bedford for both the larger Dunn Memorial Hospital and the Atomedic Hospital, and when both are completed, medical services available locally will be greatly expanded.

The Atomedic Hospital is now involved in legal, financial and tax matters which are being processed, but which also take time. But it will not be long, we are told, before these matters will be taken care of and the project given the final green light.

Bedford is not alone in the problem of hospital bed shortage, but it appears that this area will be coming nearer meeting its needs in the next few years than a lot of other cities and counties.

It is estimated that Indiana will need at least 7,000 additional hospital and nursing home beds by 1972 and may have to modernize about 30% of existing beds because they are considered obsolete.

Dr. Andrew C. Offutt, state health commissioner, said a few days ago that the Board of Health's 1967 edition of the Indiana Hospital and Health Facilities plan shows the state will need 21,751 general hospital beds and 19,358 long-term care beds within five years. The state now has 18,232 general beds, and 15,966 long-term care beds. — *Bedford Daily Times-Mail*, Aug. 25, 1967.

Doctor Shortage Goes On

Soon, now, a carefully screened new class of young men and women will enter the nation's medical schools. And in due time — from five to 10 years hence, depending on the time served in internship, residency training and the like — the bulk of these men and women will enter the private practice of medicine.

When they do, there will still be a doctor shortage. The severity of that shortage will depend on how effectively hospitals and the medical profession co-operate in working toward optimum use of our varied health service.

No matter what is done, there will be too few doctors to provide top-notch care for the entire population. Nor is the problem of distribution likely to have been solved by then. But, short of training a lot more doctors than present medical schools can handle, steps could be taken to ameliorate the problems.

Valuable suggestions emerged from the White House conference on medical costs last June. Though cost was the focal point, some of the proposals

FOURTH ESTATE

Continued

also relate to the doctor shortage. Considerable attention was focused on how to increase the physician's productivity. This could be done in a number of ways — through group practice, for example, and by training other medical personnel to perform some tasks now mainly done by doctors which might be done by nurses and technicians. Better use of hospital facilities also was discussed, and this shows great promise. If a concerted effort is made to act on these and other suggestions, the situation may at least be somewhat improved by the time this year's class enters practice.—*Terre Haute Star-Tribune*, Aug. 27, 1967.

LSD's Siren Sing

The hazards of responding to the siren song of LSD have been emphasized anew by Dr. Jean Paul Smith. His position as acting director of the Food and Drug Administration's Division of Drug Studies and Statistics gives his views — set forth in the current issue of FDA Papers — particular weight.

The impact of Dr. Smith's cautionary statement is enhanced, rather than lessened, by his indicating that the exact nature and extent of LSD's damaging effects are not yet known. Young people who have any sense at all will surely be given pause by word that LSD may lead to the birth of malformed children. The fact that this is not yet certain, but is only suspected on the basis of known chromosomal damage, is cold comfort to future parents tempted to use this psychedelic drug.

Those so tempted would do well to consider the expert's strictures on the subject. He notes that whereas the user of LSD may feel "he has found the answer to life's problems, or a chemically centered religion or values that transcend his society and culture," this is an illusion. For in consequence, writes Dr. Smith, "he only

too often winds up disengaging himself from productive, focused personal and social activities and drifts aimlessly through life without social achievements to enrich his personal life."

The tragic implications in that need to be pondered, especially by the young. Fortunately there is reason to think that most young people, whether or not as the result of conscious reflection, reject the LSD siren song. As Dr. Smith puts it, "they realize that 'dropping out' hurts them and does nothing to improve our society with its vast problems." That is the crux of the matter. Using drugs as an escape is, above all, rejection of

the responsibility that rests on all of us. — *Anderson Bulletin*, Aug. 12, 1967.

Economists identify hospitals as "labor intensive" organizations. About two-thirds of every dollar received by hospitals goes out in wages and salaries. Unlike business and industry, personal services are required around the clock in a hospital each day of the year. There is a low and abrupt cutoff point in hospitals beyond which automation is virtually useless; industry is finding new machines to replace the man every day.

Professional Courtesy

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy.

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not

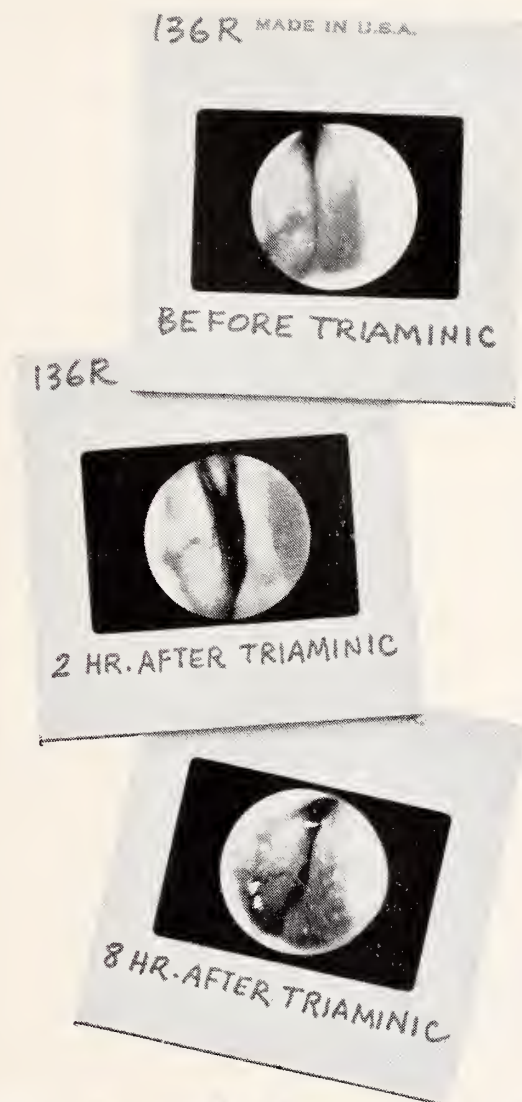
be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatment, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.—**Adopted by the Judicial Council of the American Medical Association, June 17, 1967.**

From a continuing study on nasal congestion...



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—

and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic really works.

Triaminic[®] *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride 50mg. Pyrilamine maleate 25mg. Pheniramine maleate 25mg.

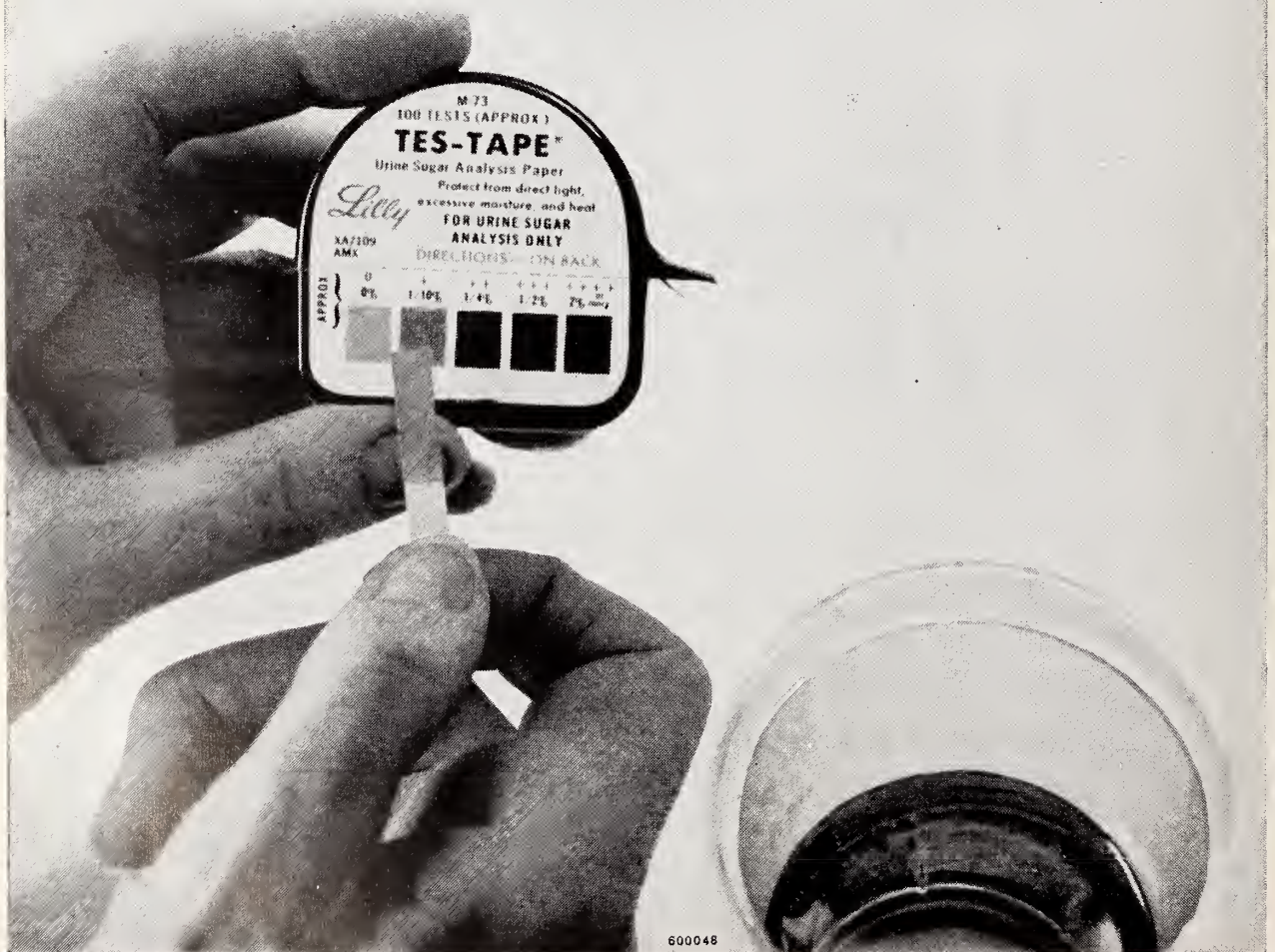
Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA 68501**

easy does it!

tear, moisten, compare—that's all!



Safe and adequate general anesthesia may be administered in a dental office by trained anesthetists with the use of Pentothal, nitrous oxide-oxygen, Penthrane and the proper equipment.

Medical Factors in Outpatient Dental Anesthesia

RICHARD M. HERD, D.D.S.

J. THAYER WALDO, M.D., D.D.S.

Indianapolis

THE Section on Oral Surgery of the University of Louisville School of Medicine gives dental trainees the opportunity to practice anesthesiology in the operating rooms under medical supervision. In order for the dentist to acquire the experience and knowledge needed to practice dental anesthesiology, he is required to explore areas far wider than those in which he would expect to practice. He is taught the basic principles of general anesthesia and the pharmacologic properties of the various general anesthetic agents.

The dentist in training realizes the standards of "dental" anesthesiology are set by the standards of "medical" anesthesiology and every advance made in the medical field forces the dentist to raise his standards. This program and others like it over the United States are beneficial to both services, acquainting each with the problems of the other and stimulating the search for technics applicable to safe outpatient dental anesthesia. This paper will explain the technics that we use in our office today.

Preoperative Preparation

As with all anesthesia, the first step is a preliminary discussion with the patient in an effort to gain some "historical facts." Has the patient been under the care of a physician? Has he had any trouble with his heart? Can he walk up a flight of stairs without becoming short of breath or developing chest pains? Is there any lung trouble?

When a patient responds that he has no morning expectoration and no morning cough, his respiratory tract is not hyperirritable and he is less likely to be a problem with bronchospasm, laryngospasm or other phenomena of the respiratory tract. We ask all our patients to cough. The typical "wet" cough is that of the chronic bronchitic or the heavy cigarette smoker, while the spastic and wheezing cough is that of the asthmatic or emphysematous patient. We also ask if there is a history of allergic or drug reaction or diabetes. Has the patient had other anesthesia? If so, what agent was used and what were his experiences?

Patients with arteriosclerosis, severe hypertension or cardiac disease are hospitalized and receive regular medical and surgical preoperative

work-up. Those with diabetes or renal disease undergo a medical consultation and are treated in the office if their conditions do not interfere with their daily activity. All patients have an examination of the heart and lungs and the blood pressure is recorded. In doubtful cases it is better to postpone general anesthesia until further data can be obtained or a more complete examination made.

No food or liquid should be ingested during the six hour period preceding anesthesia. If a mild preoperative sedative is needed to calm the patient, a non-barbituate such as Placidyl (ethchlorvynol) may be considered.

Anesthetic Technics

We use the McKesson dental anesthesia machine and follow this technic:

1. The oxygen concentration is set at 25% and nitrous oxide concentration at 75%.
2. The exhalation valve on the nose piece is left free with no pressure.
3. The rebreathing bag is left wide open, for emergencies, although the rebreathing technic is rarely needed or used.

4. The pressure regulator on the machine is used as a flowmeter and is opened sufficiently to allow a rapid flow of gases.

5. The McKesson Trilene vaporizer with a wick is half filled with Penthrane (methoxyflurane).

6. The Pentec Vaporizer can be utilized to an advantage in outpatient anesthesia.

Procedure

For the majority of our cases we use induction with a two percent solution of Pentothal (sodium thiopental). For a sleep dose of Pentothal, we used from 5 to 15cc injected intravenously over a period of about 30 seconds. The patient is usually amnesic after this injection. The nose mask is placed over the nose to begin Penthrane administration. The vaporizer is opened to from 3 to 6, and the pressure regulator is opened to from 5 to 10mm of mercury to allow a rapid flow of gases. This technic will keep most patients relaxed and amnesic with good analgesia for all office oral surgery procedures.

As a sign of onset of anesthesia when using Penthrane, the eyes usually become centrally fixed. If the eyes respond to light, the anesthesia is light. This level of anesthesia is desirable for most dental procedures. Slight dilation of the pupils may also occur during extremely light anesthesia. However, at the surgical stage of anesthesia, the pupils remain small. Overdose never occurred in this series; however, if it does occur, the pupils slowly dilate. Also, there is a marked decrease in blood pressure noted as a sign of overdose.

When the surgery is near completion, the vaporizer is shut off. With practice in anticipating the approaching end of surgery, the anesthetist will have the patient responding to command within one to three minutes after the nose piece is removed. Another nice adjunct while using Penthrane in outpatient anesthesia is that local anesthesia may also be employed to facilitate light general anes-

thesia and to aid in control of hemorrhage.

Dreams seldom occur and most patients are euphoric upon awaking. Nausea is seldom a postoperative problem.

We have used Penthrane with nitrous oxide and oxygen as sole anesthetic agents with good results. This is true with the pediatric patient and the adult who does not object to having a mask on his face. At the start of our procedure with a young patient, we ask him to hold the mask on his nose. A low flow of gases is begun and the Penthrane vaporizer slowly turned on. The bite block is placed before anesthesia is induced because we may be able to do our surgical procedures before relaxation is complete. The mouth is covered with a detachable mouth mask. Anesthesia is then induced by increasing the flow of gases until the exhalation valve on the nose mask stays open even during inspiration. The Penthrane vaporizer is slowly opened to approximately 5. The high flow of gases prevents air from entering the system, and, if the pressure at the exhalation valve is left near zero, the pressure resulting from these high flows will not be transmitted to the patient.

We are able to have most children and placid adults unconscious within *one to two* minutes. At this time the mouth mask is removed and a well-placed mouth pack inserted. This technic and the success of the anesthesia depends upon the skill with which the nose mask is held in place and the expertness of the positioning of the mouth pack. A pack placed too far back in the pharynx will obstruct respiration and the patient will become cyanotic since he is breathing neither oxygen nor nitrous oxide. A pack placed too loosely will allow air to enter the system and make anesthesia more difficult.

When Penthrane is used with nitrous oxide and oxygen for short cases, recovery time is not appreciably *prolonged*.

Profuse sweating or noisy respira-

tions are taken to mean that the anesthesia is unsatisfactory, even though cyanosis is not evident. In these instances, administration of the anesthetic is temporarily discontinued, the patient's airway is checked and cleared if necessary and anesthesia is then resumed. If we find our patients to be somewhat refractory, we use meperidine HCl intravenously rather than force the anesthetic. We found Penthrane, in most cases, to be a good muscle relaxant.

Positioning the Patient

During administration, the erect sitting position is preferred, with the chin well forward and extended, since freer drainage of blood and saliva is permitted in this position. The bite block is placed in the mouth before induction.

Penthrane possesses properties of non-flammability, and the ability to produce muscle relaxation and marked analgesia at light levels of anesthesia. According to North, W. C. et al., Penthrane has little toxicity and produces no greater effect on liver function than diethyl ether or cyclopropane.

The dental surgeon can use local anesthetic agents with epinephrine safely; this allows the patient to be kept at a very light level of anesthesia or analgesia and helps hemostasis. When Penthrane is used properly in oral surgery cases, the recovery is rapid. All of our patients in a short period of time are able to walk, with assistance, to the recovery room. The usual length of time in the recovery room is from 5 to 10 minutes. Because there may be postoperative impairment of judgment, even those patients who apparently fully recover in a few minutes *must be escorted home* by a responsible adult.

Penthrane can be used in any existing anesthetic apparatus that has a "jar"; however, with most of the cases we did this past year, we generally started with Pentothal intravenously to put our patients to sleep.

Pentothal has the peculiar property of producing complete amnesia in extremely light planes of "anesthesia." It is this "amnesic" plane rather than the surgical plane which we used for dental surgery. The patient may be moving, but if the eyes are not focusing properly, there will be no memory of the procedure. When we place the nose piece on the patient's face, nitrous oxide and oxygen is begun and Penthrane is added to the anesthetic mixture. This re-inforces the analgesic action of nitrous oxide for most dental cases in office procedures. If this technic is used expertly, it is probably the safest and, to the patient, the most satisfying available today. However, if used inexpertly, inhalation anesthesia can be very dangerous. It should never be used by anesthetists who are unable to recognize and treat respiratory arrest and laryngospasm and who do not have the moral courage to stop anesthesia when the patient does not react properly.

Resume of 634 patients
Age of office patients — 3-70 years

Surgery time:

Under 10 minutes	72%
Over 10 under 25 minutes	24%
Over 25 minutes	4%

Length of time after completion of surgery before patient leaves office under his own power with an escort.

Under 10 minutes	52%
Under 30 minutes	34%
Over 30 minutes	14%

Summary

We have presented our technic for outpatient anesthesia with a special report using methoxyflurane as an anesthetic agent. It is our opinion, at the present time, that nitrous oxide and oxygen, supplemented with Penthrane will become the "work horse" for the practice of outpatient anesthesia. It is a superior agent for analgesia and anesthesia in dentistry, easily administered, with very low incidence of nausea and is safe from fire and explosion hazards. We recommend that outpatient anesthesia be administered by qualified and trained men and that adequate equipment always be at hand.

REFERENCES

1. North, William C., Stephen, C. R.: A

Second Look at Methoxyflurane—Four Years of Experience, *Anesthesia and Analgesia*, Vol. 45, No. 1, 1966.

2. Artusio, J. F., Jr., Van Poznah, A., Hunt, R. E., Tieres, F. M., Alexander, A.: A Clinical Evaluation of Methoxyflurane in Man, *Anesthesiology* 21: 512, 1960.

3. Bagwell, E. E., Woods, E. F., Gadsden, R. H.: Blood Levels and Cardiovascular Dynamics During Methoxyflurane Inhalation in Dogs, *Anesthesiology* 23: 243, 1962.

4. Corssen, Guenter, Sweet, Robert B., Chenoweth, Maynare B.: Effects of Chloroform, Halothane and Methoxyflurane on Human Liver Cells in Vitro: *Anesthesiology*, Vol. 27, No. 2, 1966.

5. Brandt, A. L., Oakes, F. D.: Preanesthesia Medication, *Anesthesia and Analgesia*, Vol. 44, No. 1, 1965.

6. North, W. C., Stephen, C. R.: The Pentec Vaporizer for Administering Methoxyflurane Anesthesia, *Southern Med. J.* 58:158, 1965.

7. Tiers, F. M.: Methoxyflurane As An Anesthetic for Transurethral Surgery, *Anesthesia and Analgesia*, Vol. 44, No. 4, 1965.

8. Knox, P. R., North, W. C.: Methoxyflurane—A Clinical Evaluation, *Anesthesiology*, Vol. 23, No. 2, 1962.

9. Smith, R. M.: To Give or Not to Give, *Oral Surgery* 23, Vol. 6, 1965.

3989 Meadows Dr.
Indianapolis 46205

EXPANDED POSTGRADUATE MEDICAL EDUCATION PROGRAM
AT AMA CONVENTION

Physicians will have an opportunity to continue their postgraduate medical education at courses offered during the American Medical Association's Clinical Convention in Houston November 26-29.

The postgraduate program, expanded to four subjects this year, offers courses in "Fluid and Electrolyte Balance," "Oncology," "Cardiovascular Disease," and "Obstetrics and Gynecology."

Leading medical educators will lecture at the courses, which will consist of three half-day sessions each.

The courses will be limited to 200 persons each; the first 200 who register on arrival in Houston will be given tickets. There will be a special postgraduate course registration booth adjacent to the general registration area in Astro Hall.

Courses will begin promptly at 9 a.m. and 2 p.m.

This is the fifth in a series of articles describing the cancer program in Indiana as supported by the American Cancer Society. The vital need for an effective therapy for the many different types of neoplastic diseases depends on progress made both at the bedside by the clinician and in the laboratory by the investigator. The advance in the fight against cancer is closely tied together with our understanding of the control of the functions of normal cells.

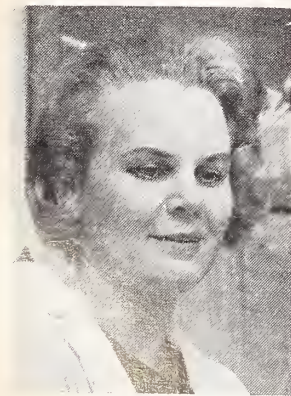
Paramecia Reveal Basic Cellular Physiology

JO ANNE MUELLER
Evansville

THE slipper-shaped, one-celled organism *Paramecium* is used extensively in research to demonstrate basic biological phenomena. The principles established for paramecia can be applied to cells throughout the animal kingdom including man.

The specific problem with which I am involved concerns infected or diseased paramecia, illustrating again that "little fleas have lesser fleas upon their backs to bite them." The finding of a diseased strain of paramecia (by T. M. Sonneborn) excited the scientific community, but we have since

learned that many such protozoans exist. Over the years, protozoans have been found to be afflicted with a variety of anomalies including met-



abolic inadequacies, diseases and genetic aberrations. Thus, the elucidation of systems in these superficially "simple" animals can provide invaluable insight into an under-

standing of similar anomalies in more complex animals.

The infected paramecia with which I work release toxin into their fluid medium. This toxin is taken into normal paramecia causing them to undergo a series of changes that culminate in death. In other words, infected or killer cells survive, proliferate, and destroy normal cells.

Several questions are currently being asked about infected killer paramecia. First, why are the killer cells immune to the poison they eject into their environment? Heretofore, it was thought that while the killer paramecia contain toxin, the toxin was not located in a susceptible part of the cell. However, I recently demonstrated that the toxin, after it is ejected from the animal, is again taken into the cell by the same pathway it is taken into normal (sensitive) cells; i.e., via the food vacuoles. Apparently, the infected paramecium can cope with the toxin so as to make it ineffective against itself. Is there an anti-toxin present? If so, it would be the first known in any organism other than vertebrates. Or, does the toxin become adsorbed onto something in the killer cell which is not present in

the sensitive cell? Experiments are underway to find the answer to this perplexing question.

Secondly, a mixed culture of normal and killer (or infected) paramecia will eventually be composed of all killer cells; the normal cells will be destroyed. It is of interest to know how the mixed cell populations fluctuate under a variety of conditions, including kind and amount of food, temperature, presence of various chemicals and the density of the interacting populations. Again, the information gathered from this type of study can be applied to other afflicted animals. For instance, if an increase in metabolic rate favors the growth of diseased cells over normal cells, then obviously to hold the disease in check, a lower metabolic rate would be desirable.

Through this kind of experimentation, an understanding of certain aspects of cellular biology is emerging. The comprehension of cellular activities is essential before ways of attacking the problems of diseased and malfunctioning cells can be developed. ◀

University of Evansville
Evansville

**Pick one to die.
Pick one for jail.
Pick one to waste away.
Pick three for happiness.**

Space contributed as a public service by this magazine.



Some children find happiness easily. Others need the help and guidance only a trained person can provide, medical attention they cannot afford, love they have been denied. When you decide to give to your United Fund or Community Chest, you may change a life.

Your fair share gift works many wonders/THE UNITED WAY



27 million families benefit by child care, family service, youth guidance, health programs, disaster relief and services for the Armed Forces from 31,000 United Way agencies.

Study of 13 children born eight months after the peak of the 1963-1965 rubella epidemic shows typical findings in 12 cases of Rudolph's "Expanded Rubella Syndrome."

Congenital Rubella Syndrome: Experience With 13 Cases

ERIC L. EFFMANN, A.B.
GERALD J. KURLANDER, M.D.
Indianapolis*

GREGG, in 1941, reported the occurrence of cataracts, microphthalmia and congenital heart disease in 78 newborns whose mothers had rubella in the early months of pregnancy.⁵ Subsequently other abnormalities such as microcephaly, deafness and characteristic dental deformities were found in the offspring of mothers who had rubella during the first trimester.^{4,17} In 1962 Weller and Neva¹⁸ and Parkman et al.⁹ working independently, succeeded in isolating the rubella virus with tissue culture technics. These technics, along with refinements in serological analysis, permitted epidemiological studies during the 1963-1965 rubella epidemic in the United States.¹² During this epidemic Rudolph et al. discovered infants who had, in addition to eye and heart defects, growth retardation, thrombocytopenia with purpura, hepatosplenomegaly, encephalomyelitis and characteristic roentgen changes in the skeleton.¹⁴ The rubella virus was cultured from most of these infants, some of whom were found to be contagious for long periods after birth. Other lesions encountered during this epidemic are summarized in Table I.

The purpose of this report is to re-

*From the Department of Radiology, Indiana University Medical Center, 1100 W. Michigan St., Indianapolis 46207.

Mr. Effmann is currently an intern in the Department of Pediatrics, Yale-New Haven Hospital, 333 Cedar St., New Haven, Connecticut.

view the experience with the congenital rubella syndrome at the Indiana University Medical Center (IUMC) resulting from the 1963-1965 rubella epidemic. Roentgen changes in the skeletal system will be emphasized.

Material and Methods

Charts and roentgenograms coded with the congenital rubella syndrome as a major or minor diagnosis were reviewed. To be included in this study, in addition to being born approximately nine months after the peak of the rubella epidemic in Indiana, cases must have had three or more of the following disturbances: cataracts, congenital heart disease, deafness, microcephaly, intrauterine growth retardation, thrombocytopenia with purpura, hepatosplenomegaly, central nervous system signs (psychomotor retardation, spasticity) or skel-

etal changes.

Intrauterine growth retardation was considered to exist when the birth weight was lower than that expected for the gestational age, e.g., less than 2,500 gms. at 40 weeks. Hepatomegaly was suspected when the liver edge was palpable three or more centimeters below the right costal margin. Splenomegaly was suspected when the spleen edge was palpable below the left costal margin.

Attempts at isolation of the rubella virus from the throat and urine were made in most cases, but the advanced age at the time of admission (average age 3.5 months) and technical difficulties precluded recovery of the virus in all but one case.

Results

Ten of our 13 cases had a clear history of maternal rubella in the first

FINDINGS IN THE CONGENITAL RUBELLA SYNDROME

Common	Uncommon or Rare
Low birth weight	Glaucoma
Cataracts	Hazy or cloudy cornea
Microphthalmia	Dental deformities
Iris hypoplasia	Myocarditis
Chorioretinitis	Interstitial pneumonitis
Deafness	Hepatitis
Congenital heart disease	Dermatoglyphic changes
Hepatosplenomegaly	Full fontanel
Thrombocytopenic purpura	Spasticity
Microcephaly	Cerebrospinal fluid pleocytosis
Psychomotor retardation	Hypoplastic anemia
Bone lesions	Hemolytic anemia

TABLE 1

trimester. One mother reported an exposure to typical rubella but did not develop the rash. The other two mothers had neither skin rash nor exposure history. The birth dates of the patients ranged from October 8, 1964, to February 9, 1965, grouping them approximately eight months after the peak of the rubella epidemic in Indiana.⁸

The average birth weight of the 13 cases studied was 2,287 gms., with only four weighing more than 2,500 gms. (Table 2). In all cases the weight at the time of admission was below the third percentile by standard age-weight charts. Six of the 13 were males and seven were females. The most common reason for hospitalization was "failure to thrive," the others being cataracts, congenital heart disease, pneumonitis and purpura. Eye lesions were encountered in eight of our 13 cases (62%) with cataracts being the most frequent. Five cases had hearing deficits (38%). Congenital heart disease was present in more than two-thirds of the cases with the combination of patent ductus arteriosus and pulmonary stenosis (valvular and/or postvalvular) being the most common finding. Hepatomegaly was noted in five cases (38%), splenomegaly in 10 cases (77%) and purpura in two cases (15%). Six of the 13 cases (46%) were retarded in psychomotor development as shown by their failure to achieve normal developmental

milestones at appropriate ages. Two had microcephaly (15%). Twelve of the 13 cases (92%) had roentgen evidence of skeletal abnormality.

Discussion

The birth dates of the affected infants correlated well with first trimester maternal infection during the peak of the rubella epidemic in Indiana.⁸ The incidence of the various clinical findings in our 13 cases is consistent with those of other series with the exception of neonatal purpura.^{3,6,7,10,13} Whether the low incidence of purpura in the first weeks of life in our cases is attributable to a failure in obtaining a precise history from informants or a truly low incidence is not clear.

Psychomotor retardation present in six of our cases emphasizes the frequency of central nervous system involvement. Because of the high incidence of deafness, thorough periodic audiometric evaluation of patients with this syndrome should be done since hearing deficits are often clinically inapparent and may become manifest at any time in infancy or childhood. The one case from which the rubella virus was recovered had pneumocystis carinii pneumonitis. This organism is a not infrequent cause of pneumonitis in chronically ill infants.

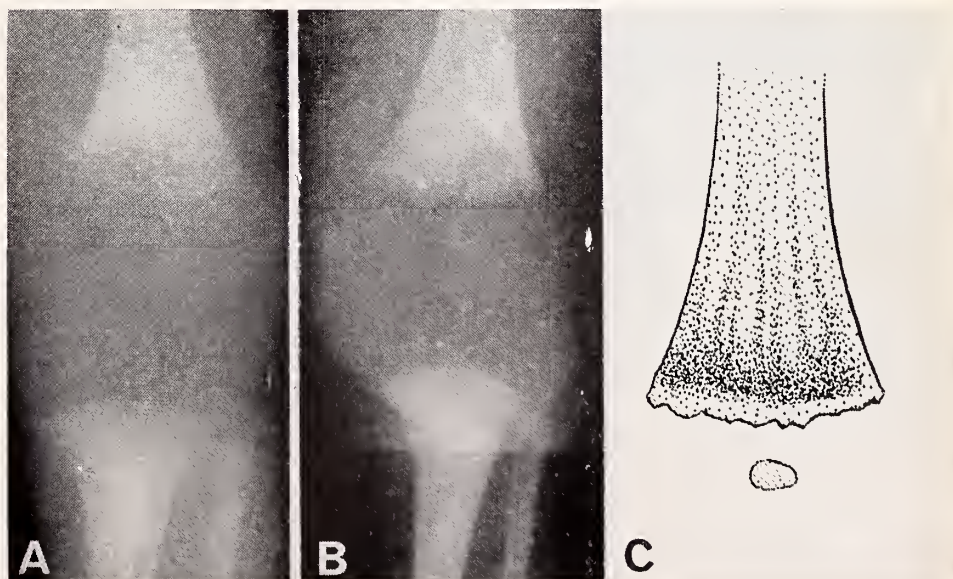
Twelve of the 13 cases had roentgen evidence of skeletal abnormality.

These changes were most severe in the newborn period consisting of irregular metaphyseal margins (zones of provisional calcification) with coarse trabecular architecture (Figure 1). There were alternating longitudinal bands of lucency and sclerosis in the metaphyses. These changes tended to disappear as the general condition of the infant improved, usually by the end of the third month. Those cases following a more chronic clinical course showed smooth sclerotic metaphyseal margins, with submetaphyseal lucent zones for as long as one year (Figures 2, 3). Either profound in utero infection or, more likely, persistence of infection accounts for this generalized disturbance in endochondral bone growth.¹⁶ Delay in appearance of ossification centers, (Figure 4) poor calvarial ossification and large anterior fontanels are further evidence of retardation in growth and maturation.^{11,13,16} Thus, the rubella virus seems not only to be responsible for retarded intrauterine growth but also in some cases, to affect the extrauterine skeletal growth.

Although other viral infections such as lymphogranuloma venereum, cat-scratch fever, smallpox, vaccinia and cytomegalic inclusion disease have been reported to involve bone, none produces changes identical to those observed in the congenital rubella syndrome.^{1,2,15} The lack of inflammatory signs and the rapid and

FIGURE 1

(1a). FRONTAL roentgenogram of a normal left knee at age one week. (1b). Frontal roentgenogram of the left knee of Case 13 at age 15 days shows irregularity of the margin of the distal femoral metaphysis with longitudinal zones of sclerosis in the metaphyses of the distal femur and proximal tibia. (1c). Diagram of the distal femur from Figure 1b.



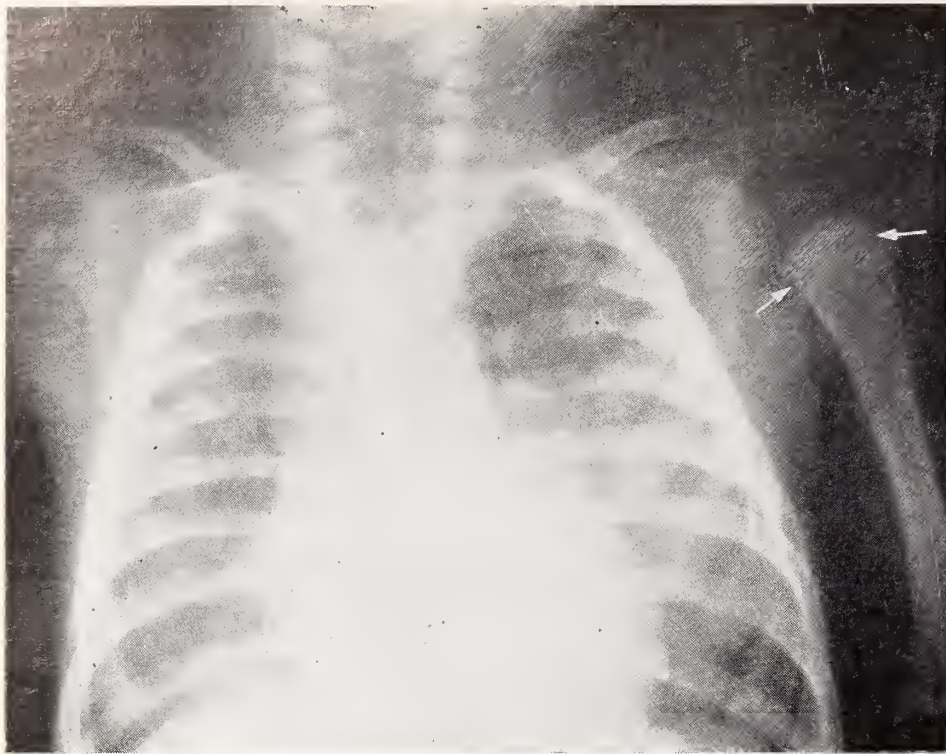


FIGURE 2
FRONTAL chest roentgenogram of Case 3 at age seven months. The ribs are broad. The proximal metaphyseal margin of the left humerus is smooth and sclerotic with a sub-metaphyseal transverse lucent zone (arrows).

Case	Sex & Age*	Birth Weight	Eye	Hearing Deficit	Heart	Hepatomegaly	Splenomegaly	Purpura	Bone	Other
1	F 3½ Mo	2,525			PDA (1)	+	+		+	Pneumocystis carinii pneumonia
2	F 3 Da	2,412	Cataract o.d.		PDA (2)	+	+		+
3	M 6½ Mo	2,625					+		+	Psychomotor retardation
4	F 5 Mo	1,489				+			+	Spasticity
5	M 11 Mo	1,958	Cataract o.u.	Mild	PS (2)				+	Large anterior fontanel, psychomotor retardation
6	F 5½ Mo	2,214	Cataract o.u.	Severe	PDA, ASD, PPS (1)	+	+		+	Inguinal hernia, bilateral
7	M 4 Da	2,099	Chorio-retinitis	Moderate	PDA, PS (2)		+		+	Calcaneovalgus
8	M 1½ Mo	2,666			PDA, PPS (1)	+	+		+	Psychomotor retardation, ureteral reflux
9	M 6 Mo	2,436	Cataract o.d.				+		+	Psychomotor retardation
10	F 7 Da	2,280	Cataract o.u.				+		+	Psychomotor retardation
11	M 1 Da	2,436			PH (1)		+	+	+	Jaundice, microcephaly
12	F 7 Mo	2,710	Cataract o.d., microphthalmia	Severe	PDA, PPS (1)					Flat feet
13	F 2 Da	1,880	Glaucoma	Severe	PDA, PS (2)		+	+	+	Jaundice, large anterior fontanel, microcephaly, psychomotor retardation

*Age at admission

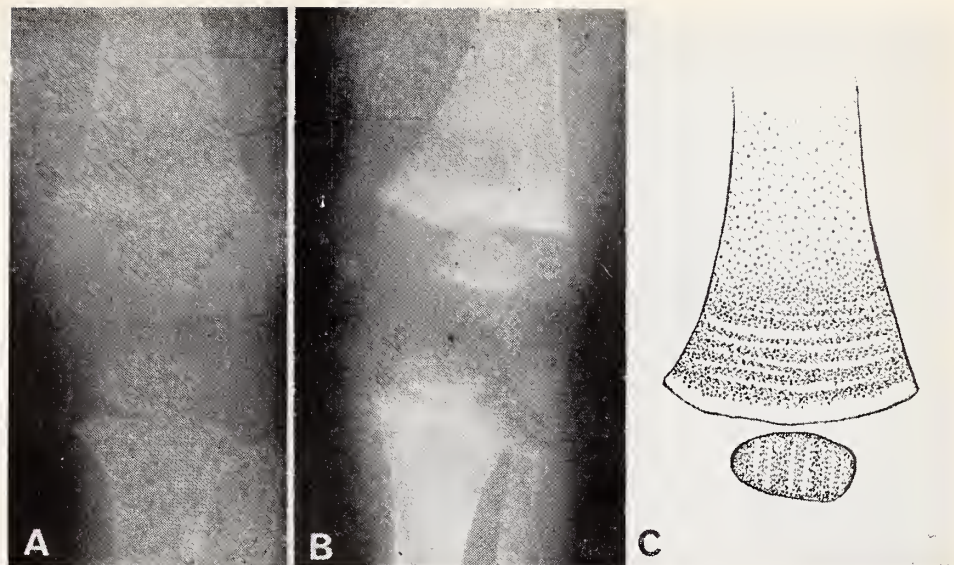
PDA = Patent ductus arteriosus
 ASD = Atrial septal defect
 PPS = Postvalvular pulmonary stenosis

PH = Pulmonary hypertension
 PS = Pulmonary valve stenosis
 (1) = Cardiac catheterization
 (2) = Clinical appraisal

TABLE 2

FIGURE 3

(3a). FRONTAL roentgenogram of a normal left knee at age seven months. (3b). Frontal roentgenogram of the left knee of Case 10 at age seven months. The distal femur and proximal tibia and fibula disclose smooth sclerotic metaphyseal margins with alternating transverse bands of lucency and sclerosis. (3c). Diagram of the distal femur from Figure 3b.



complete healing of the long bone lesions make viral osteomyelitis unlikely. The mechanism of production of the bone lesions is probably a non-specific trophic effect on endochondral bone growth. From the roentgen point of view the differential diagnosis of the skeletal lesions includes congenital syphilis, hypophosphatasia, metaphyseal dysostosis, and rickets, but the pattern particularly in early infancy is sufficiently specific to suggest the correct diagnosis. In difficult cases, appropriate clinical and laboratory studies will serve to differentiate these lesions.

Many infants with the congenital rubella syndrome born during the 1963-1965 epidemic showed a wider range of abnormalities than the tetrad of cataracts, deafness, congenital heart disease and microcephaly of previous epidemics. This led Rudolph et al.¹⁴ to divide patients into three groups: (1) "Expanded" rubella syndrome of intrauterine growth retardation, eye defects, cardiac defects, hepatosplenomegaly, thrombocytopenic purpura, bone changes and a full fontanel with a positive history of maternal rubella. (2) "Classic" rubella syndrome with eye and cardiac defects with or without a history of maternal infection. (3) Positive history of maternal rubella with a presumably normal baby. When this classification is applied to our study, Case 12 fits into the "classical" group

and the remaining 12 cases represent the "expanded" syndrome. Either these "expanded" findings were present, but undescribed, before the 1963-1965 epidemic or they were attributable to a more virulent infection by the same or a different viral strain.

Summary

Thirteen cases of the congenital rubella syndrome seen at the Indiana University Medical Center are reviewed with special emphasis given to the roentgen changes.

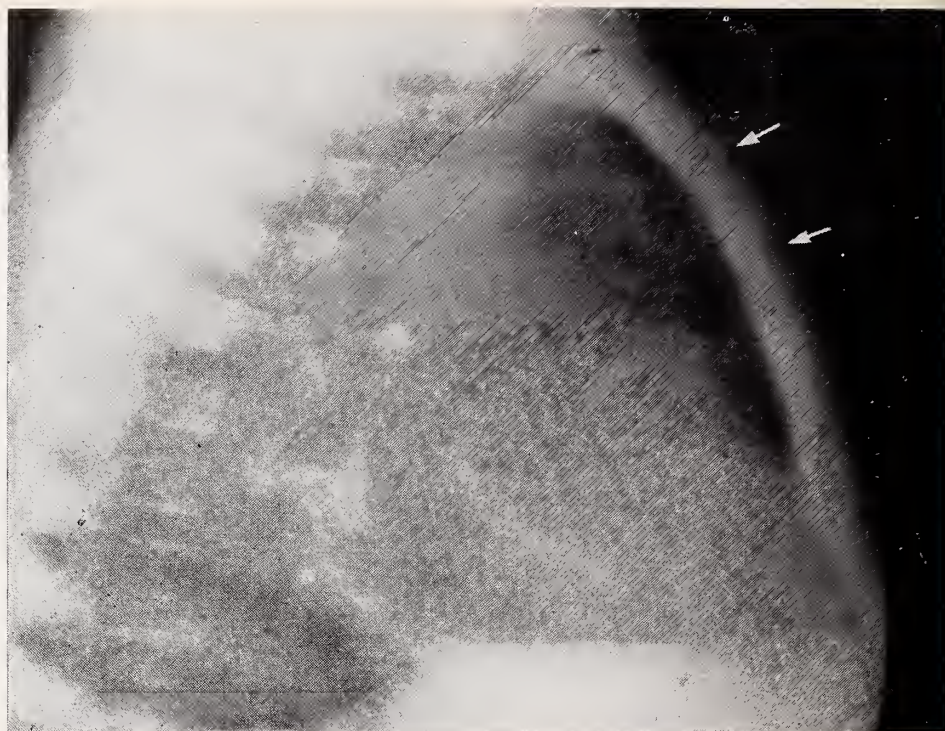
BIBLIOGRAPHY

1. Adams, W. C., Hindman, S. M.: Cat-Scratch Disease Associated With an Osteolytic Lesion, *J. Pediat.* 44:665-669, June, 1954.
2. Cockshott, P., MacGregor, M.: Osteomyelitis Variolosa, *Quart. J. Med.* 27:369-387, 1958.
3. Cooper, L. Z., Green, R. H., Krugman, S., Giles, J. P., Mirick, G. S.: Neonatal Thrombocytopenic Purpura and Other Manifestations of Rubella Contracted in Utero, *Am. J. Dis. Child.* 110:416-427, October, 1965.
4. Evans, M. W.: Congenital Dental Defects in Infants Subsequent to Maternal Rubella During Pregnancy, *Med. J. Aust.* 2:225-228, September 2, 1944.
5. Gregg, N. McA.: Congenital Cataract Following German Measles in the Mother, *Trans. Ophthalm. Soc. Aust.* 3:35, 1941.

6. Horstmann, D. M., Banatvala, J. E., Riordan, J. T., Payne, M. C., Whittemore, R., Opton, E. M., Florey, C.: Maternal Rubella and the Rubella Syndrome in Infants, Epidemiologic, Clinical and Virologic Observations, *Am. J. Dis. Child.* 110:408-415, October, 1965.
7. Lindquist, J. M., Plotkin, S. A., Shaw, L., Gilden, R. V., Williams, M. L.: Congenital Rubella Syndrome as a Systemic Infection. Studies of Affected Infants Born in Philadelphia, U.S.A., *Brit. Med. J.* 2:1401-1406, 1965.
8. Marshall, A. L., Jr.: Personal Communication. Cases of rubella reported to the Indiana State Board of Health in 1964, January, 257; February, 949; March 2, 238; April 3, 887; May 3, 777; June 1, 343; July, 283.
9. Parkman, P. D., Buescher, E. L., Arntstein, M. S.: Recovery of Rubella Virus from Army Recruits, *Proc. Soc. Exp. Biol. Med.* 111:225-230, 1962.
10. Plotkin, S. A., Oski, F. A., Hartnett, E. M., Hervada, A. R., Friedman, S., Gowing, J.: Some Recently Recognized Manifestations of the Rubella Syndrome, *J. Pediat.* 67:182-191, August, 1965.
11. Rabinowitz, J. G., Wolf, B. S., Greenberg, E. I., Rausen, A. R.: Osseous Changes in Rubella Embryopathy, *Radiol.* 85:494-499, September, 1965.
12. Rubella Symposium: *Amer. J. Dis. Child.* 110:345, 1965.

FIGURE 4

LATERAL chest roentgenogram of Case 6 at age seven months shows absence of sternal ossification centers (arrows).



13. Rudolph, A. J., Singleton, E. B., Rosenberg, H. S., Singer, D. B., Phillips, C. A.: Osseous Manifestations of the Congenital Rubella Syndrome, *Amer. J. Dis. Child.* 110:428-433, October, 1965.
14. Rudolph, A. J., Yow, M. D., Phillips, C. A., Desmond, M. M., Blattner, R. J., Melnick, J. L.: Transplacental Rubella Infection in Newly Born Infants, *JAMA* 191:843-845, March 8, 1965.
15. Sacrez, R., Fruhling, L., Korn, R., Juif, J.G., Francfort, C., Geiger, R.: Three Cases of Cytomegalic Inclusion Disease, *Arch. Franc. Pediat.* 17:129-142, 1960.
16. Singleton, E. B., Rudolph, A. J., Rosenberg, H. S., Singer, D. B.: The Roentgenographic Manifestations of the Rubella Syndrome in Newborn Infants, *Amer. J. Roentgenol.* 97:82-91, May, 1966.
17. Swan, C., Tostevin, A. L., Moore, B., Mayo, H., Black, G. H. B.: Congenital Defects in Infants Following Infectious Diseases During Pregnancy, With Spe-

cial Reference to the Relationship Between German Measles and Cataract, Deaf-Mutism, Heart Disease, and Microcephaly and to the Period of Pregnancy in Which the Occurrence of Rubella is Followed by Congenital Abnormalities, *Med. J. Aust.* 2:201-210, 1943.

18. Weller, T. H., Neva, F. A.: Propagation in Tissue Culture of Cytopathic Agents from Patients with Rubella-like Illness, *Proc. Soc. Exp. Biol. Med.* 111:215-225, 1962.

About Our Cover

Fall in Indiana always calls for treks to Brown County and to an orchard for apples and/or cider.

Jerry R. Robinson, a former Indianapolis resident and award-winning photographer, took the picture on this month's cover. His letter explains:

"When we were living in Indianapolis, we visited the Lilly Orchard regularly in the fall for cider, apples and the general atmosphere that prevails there. While standing in line with my prospective purchases, I spied the apple polishing machine in the corner, partially illuminated by a dirty window. Although the machine is used regularly, it appeared to me that the apples could have been there for years just waiting to be polished some day.

"Although I had been standing in line for quite some time and was just ready to part with my money, the 'picture' erased all of these considerations from my mind and I dashed to the car for my camera. Cider et al. is virtually unheard of here in Louisiana and we will certainly miss fall in Indiana and all that it has to offer."—J.F.S.



Let's be specific about Campbell's Soups... and reducing diets



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

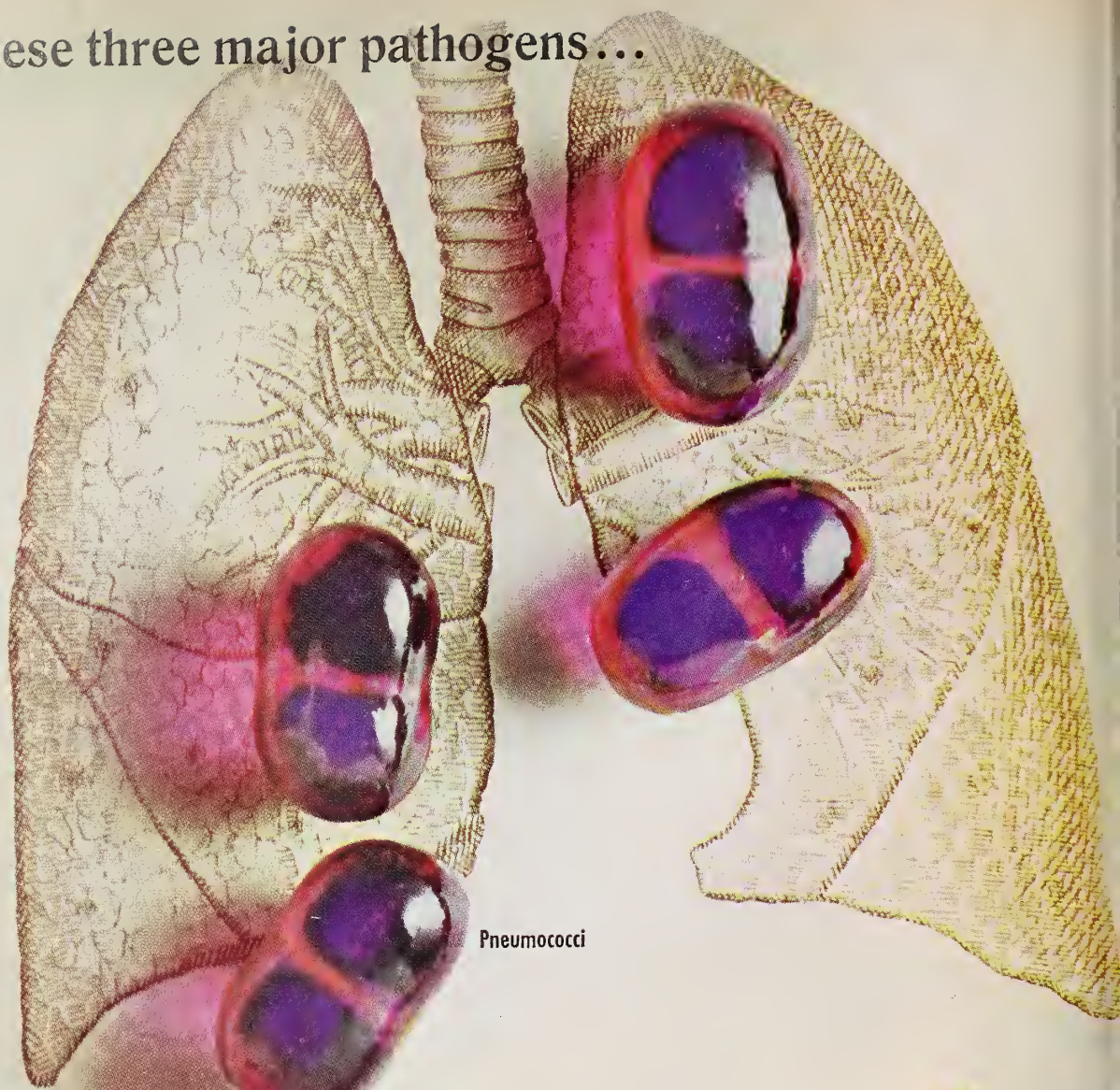
One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



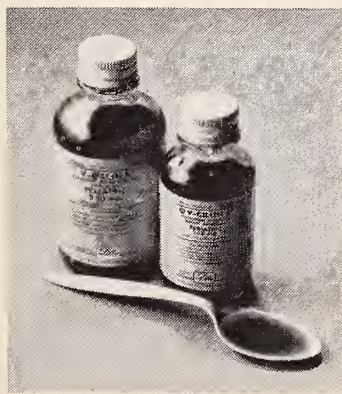
V-Cillin K[®] provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.



V-Cillin K[®] 701297 **Potassium Phenoxymethyl Penicillin**

Now available: V-Cillin K[®], Pediatric,
for Oral Solution, 250 mg. (400,000 units)
per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K is the potassium salt of V-Cillin® (phenoxy-methyl penicillin, Lilly). This chemically improved form combines acid stability with immediate solubility and rapid absorption. Higher serum levels are obtained more rapidly with this penicillin than with equal oral doses of penicillin G. The higher serum levels and acid stability of V-Cillin K make it a more dependable penicillin for oral use.

V-Cillin K, Pediatric, is an oral solution of clinically proved V-Cillin K in teaspoon dosage form. When mixed as directed, each 5 cc. (approximately one teaspoonful) will contain 125 mg. (200,000 units) phenoxymethyl penicillin as the potassium salt.

Indications: V-Cillin K has been shown to be effective in the treatment of streptococcus, pneumococcus, and gonococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy and tooth extraction in those patients with a history of rheumatic fever or congenital heart disease.

Contraindication: V-Cillin K should not be administered to a patient with a history of penicillin hypersensitivity.

Warnings: In rare instances, the use of penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin and in those with bronchial asthma or other allergies. Resuscitative drugs should be readily available for emergency administration. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for relief of immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: V-Cillin K should be used cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, its administration should be discontinued, and appropriate measures should be taken.

Adverse Reactions: Although serious allergic reactions are much less common with administration of oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it does possess a significant index of sensitization. The following hypersensitivity reactions associated with the use of penicillin have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: For Tablets V-Cillin K and for V-Cillin K Pediatric, the usual dosage ranges from 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, the daily dosage may be 50 mg. per Kg. of body weight divided into three doses.

Beta-hemolytic streptococcus infections without associated bacteremia may be treated with 200,000 to 400,000 units three times a day. Therapy should be continued for a minimum of ten days to prevent development of rheumatic fever and/or other serious complications. Dosage for routine streptococcus prophylaxis in patients with a history of rheumatic fever or congenital heart disease may be 200,000 units once or twice daily. When such patients undergo tonsillectomy, tooth extraction, or other minor surgery, the prophylactic dose should be 500,000 units every six hours given two days prior to surgery and for two days postoperatively. If oral medication is not feasible on the day of surgery, parenteral therapy should be considered. Mild to moderately severe pneumococcus pneumonia has been treated effectively with 250 mg. every six hours.

In staphylococcus infections, 400,000 units or more should be given every six to eight hours in conjunction with indicated surgical procedures.

For gonorrhea in males, 500 mg. (800,000 units) every four hours for three doses may be employed; in females, 500 mg. every four hours for six doses are recommended. Refractory infections generally respond to a second treatment three to four days following completion of the first. Treatment of gonorrhea with severe complications should be individualized, with prolonged and intensive treatment. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving penicillin and monthly serologic tests for a minimum of three months.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), in bottles of 50 and 100; and 250 mg. (400,000 units) and 500 mg. (800,000 units), in bottles of 24 and 100.

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) per 5 cc. of solution, in 40, 80, and 150-cc.-size packages. [032067]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

Mediastinoscopic investigation will often obtain information which will permit more effective ablative surgery or clearly contraindicate a proposed thoracotomy.

Mediastinoscopy—A Safe, Practical Technic

HARRY SIDERYS, M.D.
JOHN N. PITTMAN, M.D.
Indianapolis*

UNTIL recently, mediastinal exploration and biopsy of mediastinal lymph nodes was possible only by major thoracotomy. Although Harkens¹ in 1954 described a method for cervicomediastinal exploration, it was Carlens² of Stockholm, who in 1959, reported his experience in over 100 patients and established this technic as a safe and useful one. The procedure has been widely accepted and practiced in Europe^{3,4} but has received limited attention on this continent.^{5,6,7}

We have found mediastinoscopy to be safe, informative and technically simple to perform.

Technic

The patient is anesthetized, intubated and placed in reverse Trendelenberg position with the neck extended. A transverse incision about 3 cms long is made just above the suprasternal notch and is carried down to the trachea. If scalene fat pad exploration or excision is to be done simultaneously, a thyroid incision is used. The pretracheal fascia is incised and, using blunt finger dissection, the fascia is elevated from the trachea down to the carina (Figure I). Using the left index finger one can readily identify the aortic arch, the innominate and left carotid arteries, the carina and the anterior aspect of the right and left main stem bronchi. Lymph nodes can be identified and partially dissected free by

digital manipulation.

After the mediastinum has been thoroughly explored by the finger, the mediastinoscope is introduced for obtaining a specimen for biopsy or excision of lymph nodes under direct vision (Figure II). Hemostasis is accomplished by temporary packing or cautery. The wound is closed without drainage.

Case Reports

Case No. 1. A 32-year-old white female was admitted after a routine roentgenogram of the chest revealed bilateral hilar adenopathy (Figure III). She appeared to be in good health and denied all symptoms that might be related to her chest or cardiorespiratory system. Physical examination was without abnormal findings. No enlarged lymph nodes were palpable and percussion and auscultation of the chest were normal. The

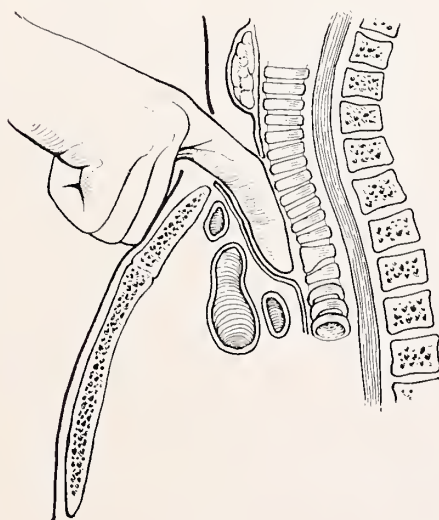


FIGURE I
THE fascia is elevated from the trachea down to the carina by using blunt finger dissection.

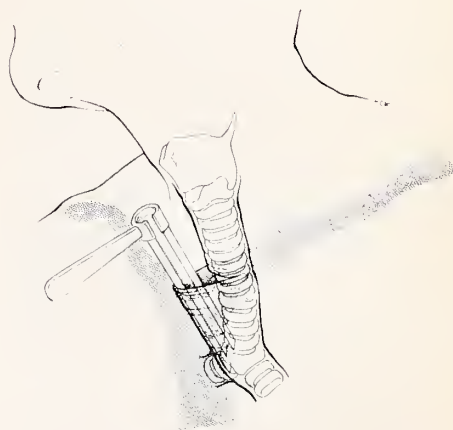


FIGURE II
THE mediastinoscope is then introduced for obtaining a specimen for biopsy or excision of lymph nodes.

differential diagnosis prior to surgery included sarcoidosis, mediastinal lymphoma and tuberculosis.

A thyroid incision was made; examination of the retroclavicular area of the neck, including the scalene fat pad, revealed no nodes suitable for



FIGURE III
CASE No. 1: Roentgenogram of the chest reveals bilateral hilar adenopathy.

*From the Department of Thoracic & Cardiovascular Surgery, Methodist Hospital Graduate Medical Center, 1604 N. Capitol Ave., Indianapolis.

biopsy. The pretracheal fascia was incised and the left index finger introduced into the mediastinum. Many enlarged soft nodes could be easily detected under the aorta arch and on either side of the trachea. One of these was teased free by digital manipulation and delivered for frozen section. The pathologist's impression was sarcoidosis. A number of other nodes were removed for biopsy. There was no significant bleeding and primary closure wound was employed. Permanent section confirmed the diagnosis of sarcoidosis.

Case No. 2. A 50-year-old white male was admitted with a history of cough and shortness of breath for two weeks prior to admission. Roentgenographic examination of his chest revealed a lesion in his left hilum (Figure IV).

Bronchoscopy with biopsy of a lesion near the origin of the left upper lobe bronchus was performed. Microscopic examination revealed undifferentiated carcinoma. Because of the anaplastic nature of the lesion, it was felt mediastinoscopy was indicated to evaluate the degree of mediastinal spread. On exploration there was no supraclavicular adenopathy. Mediastinoscopy was performed and numerous nodes containing metastatic malignancy were found on both sides

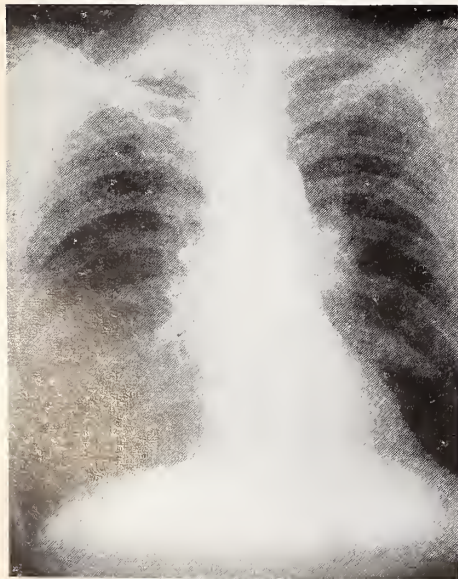


FIGURE IV
CASE No. 2: A lesion of the left hilum in this patient is readily apparent.



FIGURE V
CASE No. 3: This patient was admitted to the hospital because of hilar adenopathy.

of the mediastinum. The patient was subsequently treated with cobalt irradiation.

Case No. 3. A 56-year-old Negro female was admitted to the hospital because of hilar adenopathy (Figure V). She had noticed substernal chest pain of increasing severity for two years prior to admission. In the few weeks prior to admission she experienced anorexia, weight loss, fever to 102° and finally profound weakness. Shortly after admission the patient became jaundiced, accompanied by elevations of alkaline phosphatase (19) and SGPT (340). Liver biopsy revealed only cholestatic jaundice.

Bilateral scalene node biopsy revealed reactive hyperplasia of some small lymph nodes. A lymphangiogram showed no abnormal lymph nodes in the pelvis or abdomen and bronchoscopy findings were normal. Finally, mediastinoscopy was done and a tight band of markedly enlarged lymph nodes was found encircling the trachea just above the carina. These were separated by digital manipulation, apparently relieving the pressure on the trachea. These nodes and the right and left paratracheal lymph nodes were partially removed for biopsy. The final interpretation of these nodes was re-

active hyperplasia. The patient's jaundice cleared gradually. A cholecystogram at a later date was normal. We were not certain of the etiology of the jaundice but suspected a cholestatic hepatic reaction to Librium which the patient had been receiving prior to admission. Following mediastinoscopy the patient's voice became hoarse and indirect laryngoscopy revealed that the left vocal cord was not functioning. Symptomatically the patient was considerably improved, with cough and chest pains diminished. She was no longer jaundiced and was regaining her strength at the time of discharge. Approximately three months later her voice returned to normal.

Case No. 4. A 61-year-old white male was admitted to the hospital with a diagnosis of unresolved pneumonia thought to represent carcinoma of the lung (Figure VI). Bronchoscopy revealed only gross distortion and compression of the right upper lobe bronchus of the lung. Lamino-grams and bronchograms showed marked stenosis of the anterior segmental bronchus of the right upper lobe. Sputum examination was negative for malignant cells.

Mediastinoscopy and scalene nodes

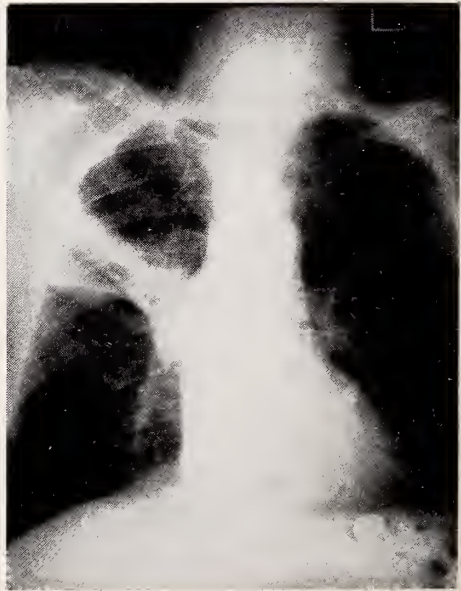


FIGURE VI
CASE No. 4: Roentgenogram taken when the patient was admitted with a diagnosis of unresolved pneumonia.

removed for biopsy showed no evidence of metastatic adenopathy. The patient was later operated upon and right upper lobectomy was done. The final diagnosis was unresolved pneumonia.

Case No. 5. A 46-year-old white male had an x-ray of the chest because of substernal pain which had been present for years but was worse shortly before admission. The patient's mother died of tuberculosis when he was three years old. Roentgenograms showed mediastinal fullness, particularly to the right (Figure VII). Laminograms confirmed the presence of right mediastinal fullness. A superior vena cavagram showed displacement of the vena cava due to a mediastinal mass. Skin test for histoplasmosis was strongly positive. He was taken to surgery and under general anesthesia, a number of small prescalene nodes were excised. Frozen section study revealed normal tissue. Mediastinoscopy was performed. A large number of mediastinal nodes were found in the right paratracheal area. Some of these were removed for biopsy. The final diagnosis was reactive hyperplasia of lymph nodes. The patient did well and was discharged.

Case No. 6. A 56-year-old white female was admitted to the hospital because a routine chest film revealed an irregularly shaped, three to four

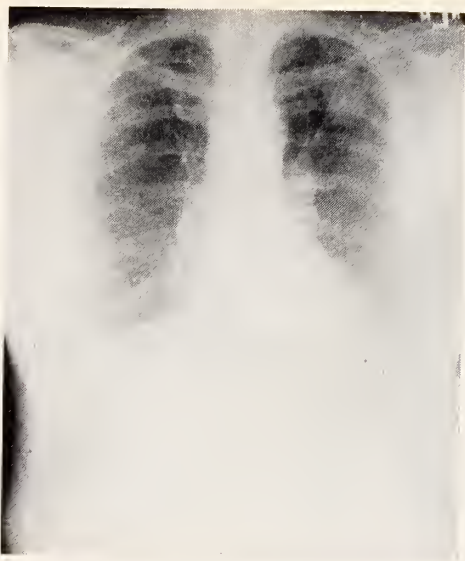


FIGURE VIII
CASE No. 6: A routine chest film revealed an irregularly shaped, three to four centimeter mass in the upper left lobe.

centimeter mass in the left upper lobe (Figure VIII). There was a suggestion of fullness in the left hilum, but the patient was totally asymptomatic. Past history included an abdominal perineal resection for carcinoma of the rectum in 1952. She had no evidence of recurrence in the intervening years. Under general anesthesia, a number of scalene nodes were removed and frozen section indicated normal tissue. Mediastinoscopy was negative. A left thoracotomy and left upper lobectomy were performed when adenocarcinoma of the lung without mediastinal metastases was found.

Case No. 7. A 61-year-old white male was admitted with a history of cough for four months prior to admission. Shortly before admission the patient developed a fever of 102° and became quite weak. Roentgenograms suggested pneumonia superimposed on carcinoma of the right upper lobe (Figure IX). Malignant cells were obtained from his sputum. Mediastinoscopy was performed and revealed extensive undifferentiated epidermoid carcinoma of the paratracheal lymph nodes on the right side up to the thoracic inlet. The prescalene nodes were not involved. It was decided to treat the patient with irradiation.

Comments

Mediastinoscopy was a valuable and informative procedure in the seven patients described. Three patients had carcinoma of the lung. The first patient, a good surgical risk, was saved a useless thoracotomy and lung resection when mediastinoscopy revealed the malignancy had spread to contralateral nodes. A second patient, who was a poor surgical risk, was spared thoracotomy when mediastinoscopy revealed extensive paratracheal metastases. The third patient was found to have negative nodes at mediastinoscopy. At subsequent thoracotomy, the absence of nodal metastases was confirmed and an adenocarcinoma of the lung was removed by lobectomy.

Most physicians would agree that patients with contralateral metastases and extensive mediastinal metastases, demonstrated by mediastinoscopy, should not be treated by pulmonary resection. The presence of ipsilateral node metastases alone does not preclude surgery as there are five-year cures among such patients.⁷ The knowledge that such metastases exist is valuable in the decision of preoperative mediastinal irradiation and/or radical mediastinal dissection at the time of surgery.

In our one patient with sarcoidosis

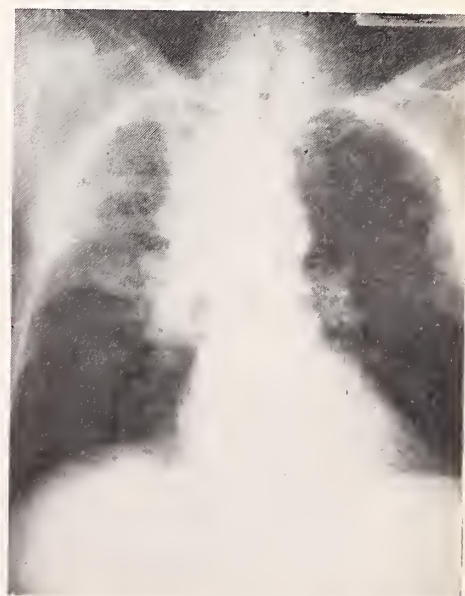


FIGURE IX
CASE No. 7: Roentgenograms taken in this case suggested pneumonia superimposed on carcinoma of the right upper lobe.



FIGURE VII
CASE No. 5: Mediastinal fullness is evident in this x-ray.

and the two patients with reactive hyperplasia of the mediastinum, the diagnosis was made without resorting to thoracotomy.

In our small series, hemorrhage, wound infection and pneumothorax did not occur. The one significant complication, left vocal cord paralysis, was only temporary.

The information obtained by mediastinoscopy in patients with carcinoma of the lung is usually quite helpful. Most authors find that one-third of their patients with carcinoma of the lung who are otherwise operable already have mediastinal metastases. Furthermore, of those patients with mediastinal metastases, more than one-third have contralateral mediastinal metastases. In Boerema's⁸ experience, prior to the use of mediastinoscopy, pulmonary resection with a cure occurred in only 60% of thoracotomies. When mediastinoscopy was employed prior to surgical resection, a cure occurred in more than 90% of cases.

There can be little doubt that the presence of contralateral nodal metastases precludes the use of pulmonary resection as curative treatment for carcinoma of the lung. Mediastinoscopy will save these patients from useless thoracotomy. The larger group with ipsilateral nodal metastases present a problem in therapy. Lobectomy or pneumonectomy with mediastinal node dissection will result in cure in a small number of these patients.⁵ The presence of ipsilateral positive nodes is not a contradiction to surgery but indicates preoperatively the need for node dissection at the time of surgery. Some physicians advocate

preoperative radiation therapy. Knowledge of the degree of involvement of mediastinal nodes in such patients should lead to more informed and intelligent care of patients with carcinoma of the lung. Mediastinoscopy has been particularly informative in the evaluation of patients with hilar adenopathy. The experience of Amer, Minkowitz and Dennis⁵ is that this procedure is much more likely to yield diagnostic information than scalene node examination alone.

One reason that mediastinoscopy has not been more widely adopted is the fear of complications. The vision of blind probing into the mediastinum raises the possibilities of hemorrhage and mediastinitis, although these complications are extremely rare in all reported series.

Reynders in over 250 patients had no significant infections and only one instance of mediastinal hemorrhage requiring thoracotomy for control.¹⁰ In addition, two patients developed pneumothorax and three patients had transient left recurrent nerve palsies. Our experience confirms that the risk of mediastinoscopy is minimal when compared with the value of the information obtained. Jepson,⁹ in more than 900 cases, observed no instances of major bleeding, only one case of pneumothorax and one case of paralysis of the left vocal cord. Mediastinitis, which responded to therapy, occurred in one patient in whom a pocket of pus was entered during the course of obtaining a mediastinal node for biopsy. No other morbidity and no mortality occurred in this large experience.

Summary

Mediastinoscopy is a safe way to explore the mediastinum and obtain lymph nodes for biopsy bilaterally from the paratracheal region down to the carina. The information thus obtained is most useful in patients with carcinoma of the lung who are being readied for thoracotomy and in patients with undiagnosed hilar adenopathy. Seven patients were subjected to mediastinoscopy and five were spared useless thoracotomy. The only complication was a temporary vocal cord paresis.

REFERENCES

1. Harkins, D. E., Black, H., Clauss, R., Fassand, R. E.: A Simple Cervicomedastinal Exploration for Tissue Diagnosis of Intrathoracic Disease, *New Eng. J. Med.* 251:1041, 1954.
2. Carlens, E.: Mediastinoscopy: A Method for Inspection and Tissue Biopsy in the Superior Mediastinum, *Dis. Chest* 36:343, 1959.
3. Seppala, A. J.: *Mediastinoscopy Duodecim*, 75:435, 1959.
4. Palva, T., Vickari, S.: Mediastinoscopy, *J. Thor. and Cardiovasc. Surg.* 42:206, 1961.
5. Amer, N. S., Minkowitz, S., Dennis, C.: Mediastinoscopy, a Useful Technique for Undiagnosed Parahilar Lesions, *Surgery* 57:665, 1965.
6. Pearson, F. G., Kergin, F. G.: Mediastinoscopy: A Method of Biopsy in the Superior Mediastinum, *J. Thor. and Cardiovasc. Surg.* 49:11, 1965.
7. Flynn, J. R., Rossi, N. P., Lawton, R. L.: *Arch. Surg.* 94:243, 1967.
8. Boerema, I.: Mediastinoscopy, A Method of Biopsy in the Superior Mediastinum, *J. Thor. and Cardiovasc. Surg.* 49:11, 1965.
9. Jepson, O.: *Mediastinoscopy Munksgaard*, Copenhagen, Denmark, 1966.
10. Reynders, H.: Mediastinoscopy in Bronchogenic Cancer, *Dis. Chest* 45:606, 1964.

Pseudohemophilia manifests itself by a tendency to bleed excessively throughout the pregnancy. It is an especially serious complication. This case was successfully managed through a succession of bleeding episodes.

Pregnancy Complicated by Pseudohemophilia (Von-Willebrand's Disease)

ROBERT E. McCAMMON, M.D.*
Homestead AFB, Florida

IN 1926 Von-Willebrand reported a hemostatic disorder in a family which he termed "pseudohemophilia."¹ He felt the disorder was inherited as an autosomal dominant. Subsequently, there have been numerous reports of cases in which diagnosis,^{2,4} pathogenesis,⁵⁻¹⁰ and treatment have been discussed.^{8,10,11,13-19} An excellent review of all cases reported up to 1955 was made by Buchanan and Leavell.²⁰

Pseudohemophilia is a hemorrhagic disorder which may occur in either sex. It is characterized by a bleeding tendency and prolongation of the bleeding time which is the only consistent abnormal laboratory finding. Other laboratory tests are usually normal although isolated abnormalities have been reported in these patients.^{2,3,7-9,11,12,18,21}

Pregnancy constitutes a definite hazard in women affected by pseudohemophilia, the most frequent complication being postpartum hemorrhage. Such a case recently occurred at Indiana University Medical Center and, because of the severity of ensuing complications, it seems worthy of report.

Case Report

A 12-year-old gravida 1, para 0,

white female was first seen at Coleman Hospital on October 18, 1965 at the request of her family physician. At this time she was estimated to be in the 37th week of pregnancy. Her last menstrual period had been in February, 1965, and her estimated date of confinement was early November. A diagnosis of pseudohemophilia had been made at two years of age. Prior to her initial visit to Coleman Hospital, her pregnancy had been complicated by several episodes of epistaxis requiring nasal packing. The patient had also had a 37 pound weight gain and noted swelling of her feet.

Menarche had occurred at age 11, menses had been regular every 28-30 days and usually lasted about eight days. She described her flow as "heavy." Between 1956 and 1958 she had had admissions to Indiana University Medical Center for epistaxis requiring packing and transfusion on two occasions; tooth extraction and gum abscess on two occasions; multiple facial lacerations and severe epistaxis resulting from an auto accident required 13 transfusions; and for gastrointestinal hemorrhage of unknown etiology, but which required transfusion. She had been seen by hematologic consultants each time and was diagnosed as having pseudohemophilia (Von-Willebrand's disease) on the basis of a prolonged bleeding time. All other blood tests were normal. She also had had many admissions and blood

transfusions at her local hospital, mainly for recurrent epistaxis usually requiring nasal packing. The family history was unobtainable. She was allergic to sulfa drugs and aspirin.

Physical examination on admission revealed a gravid 12-year-old white female who appeared older than her stated age. Temperature — 98.6°; blood pressure — 120/80; pulse — 100 beats/min.; respirations — 22/min. General physical examination was within normal limits. The uterine fundus was 28 cm. above the symphysis and abdominal palpation indicated the presence of a single fetus in a cephalic presentation with the head not yet engaged. Estimated fetal weight was 6-6½ pounds and fetal heart tones were normal. The pelvis was judged to be normal in architecture and capacity. There was moderate edema of the hands, lower legs and feet.

Laboratory data: Admitting hemoglobin was 11.1 gm.%; white blood count was 9,550 with a normal differential; platelets were normal; blood type was 0; Rh factor was absent; Coombs test was negative; Papanicolaou smear was normal; Rumpel-Leed test was negative; VDRL was non-reactive. Bleeding time (Duke) was 8 minutes, 45 seconds; Lee & White coagulation time was 15 minutes, 25 seconds; clot retraction normal; prothrombin time 12 seconds (100%); prothrombin consumption

* Formerly from the Department of Obstetrics and Gynecology, Indiana University Medical Center and Marion County General Hospital. Dr. McCammon is currently with the 823 Medical Group, SAC, Homestead AFB, Fla. 33033.

15.6 seconds; fibrinolysin was negative; fibrinogen 890 mg.%; factor VIII assay 85%; plasmin assay normal and thromboplastic generation test was normal.

Hospital Course: The patient was placed on a 3 gm. sodium diet and chlorothiazide 250 mg. twice a day. She lost nine pounds over the next 18 days in the hospital. She was seen in consultation by members of the hematology department who confirmed the diagnosis of pseudohemophilia on the basis of the above tests. They recommended having fresh whole blood available at the time of delivery. She had two episodes of epistaxis while in the hospital which required nasal packing but no transfusions. She was released to a foster home on November 5, 1965, to await the onset of labor.

She returned to the hospital on November 8, 1965, at 11:40 a.m. with a history of contractions starting the night before and progressing to every five minutes. There was slight bloody show present and membranes were intact. General physical examination was unchanged. Abdominal examination revealed a term size uterus, vertex presenting but unengaged. Fetal heart tones were normal, and estimated fetal weight was 7½ to 8 pounds. The cervix was 90% effaced and 2-3 cm. dilated with the vertex at a minus 3 station. Her hemoglobin was 11.3 gm.%. She was cross-matched and an intravenous infusion of dextrose and water was started. Her contractions became irregular and of poor quality that afternoon and she showed little progress. X-ray pelvimetry indicated the following measurements: anteroposterior and transverse measurements of the inlet were 11.3 and 13 cm. respectively. Anteroposterior diameter of the mid-pelvis was 10 cm. and the bispinous diameter was 9.9 cm. Outlet measurements indicated a posterior sagittal diameter of 6.5 cm. and a bituberos diameter of 9.0 cm. Although the pelvis was judged to be smaller

than average, it was elected to sedate and hydrate her that evening, and the following morning an intravenous oxytocin infusion was started.

A good contraction pattern was immediately established and satisfactory progress ensued. Her membranes were ruptured artificially and after 6½ hours of labor, she was taken to the delivery room. Under pudendal anesthesia with 1% lidocaine with 1:200,000 epinephrine and N₂O over a left mediolateral episiotomy by outlet forceps, a 3930 gram female infant, APGAR 8, was delivered. The placenta was expelled spontaneously and seemed complete. Intravenous oxytocin was given and also was placed in the intravenous fluids along with 500 mg. of ascorbic acid. The uterus was explored manually and it contracted well. The episiotomy was repaired with interrupted chromic catgut. Bleeding was not excessive and blood loss was estimated to be approximately 250 ml.

She was returned to bed and a pressure pack was placed against the perineum. Three hours later she passed a large clot from her vagina and had a temporary fall in blood pressure; however, she responded well to uterine massage and one unit of blood. She was also placed on ergotrate 0.2 mg. every 6 hours, orally.

Her lochia was heavy and on her first postpartum day she developed acute pyelonephritis, which responded promptly to chloramphenicol 500 mg. every six hours. Her postpartum course was otherwise uneventful and she was released on her tenth postpartum day on ferrous sulfate 900 mg. per day. Her discharged hemoglobin was 10.9 gm.%.

On December 4, 1965, she was readmitted because of heavy vaginal bleeding which had started two days after her discharge. Oral temperature was 101°F; blood pressure 102/50; pulse 120 beats/min.; respirations 22/min. Pertinent physical findings were limited to the pelvis. The cervix was approximately 3 cm. dilated and

blood was coming from it. The uterus was approximately eight weeks gestation in size, soft, and moderately tender to palpation. Her hemoglobin was 5.7 gm.% and it was felt she had endometritis and probable retained placental fragments.

She was transfused with whole blood and placed on 600,000 U of penicillin and 0.5 gm. streptomycin intramuscularly every 12 hours to which she promptly responded. A dilatation and curettage which was performed at noon the next day produced no placental fragments. The microscopic diagnosis was endometrium, involuting placental site. At the time of curettage, however, a profuse hemorrhage occurred and she went into shock. Uterine massage, intravenous oxytocin, intravenous Premarin® 40 mg. in divided doses, and intravenous phytonadine 20 mg. was given. Ascorbic acid 500 mg., soluble vitamin B-complex, and oxytocin were placed in her intravenous fluids and she was given multiple units of whole blood including fresh blood and fresh frozen plasma. Her bleeding was only partially controlled and it was decided after further consultation with the hematology department that the uterus should be packed.

That evening under general anesthesia the uterus and vagina were packed with gauze and this controlled the hemorrhage. Further transfusions of fresh whole blood and fresh frozen plasma were given and intravenous oxytocin was continued. The pack was removed 36 hours later on December 8, 1965 and she began to bleed again and had to be repacked three hours later. Further transfusions were given. She was started on Prednisone® 40 mg. per day orally at this time. Over the next three days she was packed three times either with Gelfoam® sponges or strips of Surgel®, which controlled the hemorrhage while in place but each time the uterus expelled the pack spontaneously. Further transfusions, intravenous fluids and antibiotics were given and she generally remained afebrile.

It was then decided to try an intracavitary radium application. This was done with an afterloading Fletcher tandem and gauze packing was placed around and in the vagina. She received a total of 2,700 mg. hours of radiation. The radium was removed from the tandem and the packing left in place another six days. She was continued on Prednisone, penicillin and streptomycin, ferrous sulfate, multiple vitamin preparations and remained afebrile. The bleeding ceased and she was released on December 30, 1965 on Prednisone 20 mg. per day, ferrous sulfate 900 mg. per day, and a multiple vitamin tablet. She was given 32 units of whole blood and four units of fresh frozen plasma on this admission.

Her next admission occurred 10 days later when she gave a history of starting to bleed that day from her vagina. General physical examination was within normal limits, the uterus was involuting satisfactorily and only a small amount of bleeding was noticed. She was observed for several days and continued to bleed about 3-5 pads per day. She was given one unit of blood because of a drop in her hemoglobin from 14.4 gm.% to 9.9 gm.%. The bleeding gradually ceased and she was released after a hospital stay of nine days on the same medications.

She returned three days later on January 21, 1966, complaining of vaginal bleeding; however, only a small ooze was noted. She was observed for two days and released on the same regimen. Her hemoglobin was 15.2 gm.%.

On February 4, 1966, twelve days later, she was again re-admitted with a history of heavy vaginal bleeding for the last ten days. Examination showed she was actively bleeding from the uterus, which was now normal sized. Her hemoglobin was 8.3 gm.%. She was transfused with whole blood and it was recommended that she receive further pelvic radiation. Accordingly she received 1,500 rads total pelvic dosage of external

radiation over the next eight days through an anterior and posterior port using a cobalt 60 source. Bleeding ceased and she was released on February 27, 1966, on ferrous sulfate 900 mg. per day and Prednisone 15 mg. per day. Her discharge hemoglobin was 12.0 gm.%.

On June 9, 1966, further coagulation studies were performed and the following values were obtained: Prothrombin time, normal; prothrombin consumption, 10 seconds; bleeding time (Duke), greater than 15 minutes; clot retraction, normal; partial thromboplastin, 53.8 seconds (control 33 seconds); Factor VIII assay, 22% of normal; her plasma was abnormal in the thromboplastin generation test. On September 1, 1966, her bleeding time was still greater than 15 minutes. Further tests revealed the Factor VIII assay to be 28% of normal; prothrombin consumption, 46.8 seconds; and her hemoglobin was 14.9 gm.%.

She has been observed in the outpatient clinic and has had no further vaginal bleeding; however, she has been seen twice for epistaxis. Her Prednisone has been discontinued and she remains in general good health.

Comment

Pseudohemophilia usually becomes manifest in childhood and the incidence in the two sexes is about equal. Most patients give a history of having "always" had a tendency to bleed excessively. Growth and development in childhood are usually normal, despite recurring episodes of bleeding, especially from nose and gums. Minor abrasions and trauma often produce excessive bleeding, ecchymosis and hematoma. In females the clinical manifestations may become more severe after puberty because of menorrhagia and metrorrhagia.

Pregnancy is an added hazard and it frequently terminates in a spontaneous abortion or as a term delivery complicated by severe and prolonged postpartum hemorrhage. In spite of this hazard Buchanan and Leavell²⁰

could find no reports of a maternal death during pregnancy or the postpartum period. The only possible exception is a case reported by Levy²² in which a 45-year-old woman died of a uterine hemorrhage said to be postpartum. Others^{23,24} have reported instances of uncomplicated pregnancy and delivery, yet these same patients have had other pregnancies that were complicated by hemorrhage.

At present there is no unanimity of opinion concerning the primary dysfunction in Von-Willebrand's disease. There is great variability in the bleeding tendency in a given patient from time to time which is unpredictable. The bleeding tendency does not always parallel the bleeding time^{3,8,13}, and patients may show various laboratory abnormalities at different times in their lives.^{8,23} Our patient demonstrates this in that while she was pregnant, her Factor VIII assay was within normal limits and several months postpartum, it was low. Interestingly Strauss and Diamond²⁵ have found elevated levels of Factor VIII in normal pregnant women and in a woman with Von-Willebrand's disease. Singer and Raust²⁶ distinguish a condition which they call pseudohemophilia B, to distinguish it from pseudohemophilia A (Von-Willebrand's disease), by the additional defect of a deficiency in Factor VIII (thromboplastinogen, AHG). Her bleeding time has remained prolonged and on one occasion the prothrombin consumption test was abnormal. The prothrombin consumption test has been found to be abnormal by some authors^{11,21} and normal by others^{12,14,23} in small numbers of cases of pseudohemophilia. It is difficult to distinguish a good therapeutic result from a spontaneous remission because the natural course of the disorder is so variable.

Treatment

The treatment still remains generally unsatisfactory. A gamut of chemicals including calcium¹³, rutin¹⁵, vitamin K^{13,16}, vitamin C^{13,16} and

snake venom¹³ have been used with little or no success. Jacobson¹⁴ feels that cortisone is effective for control of bleeding; however, it did not work in our patient. Nillson¹⁸ has used a specific plasma fraction, I-O. Although transfusions with fresh whole blood would seem to be indicated, many^{8,11,12,23} feel its use has been disappointing. Wendt and LaFond¹⁷ reported they successfully operated on these patients by supplementing local measures of cold and pressure with transfusion of fresh frozen plasma. Neither fresh whole blood or fresh frozen plasma seemed to control our patient's bleeding tendency, and we were forced to castrate her by radiation therapy. Uterine packing of the postpartum uterus, a practice which is not generally employed in modern obstetrics, may be helpful as a temporary life-saving measure in these women. Until more is known about the nature of the disorder, the best management would seem to be the use of supportive and symptomatic treatment, local hemostatic agents and the avoidance of all but the most urgent surgery.

Summary

A case of pregnancy complicated by Von-Willebrand's disease or pseudohemophilia is presented. The variable nature and clinical course of the disorder, its unsolved basic pathophysiology and principles of treatment are discussed.

Acknowledgment

The author wishes to thank Drs. T. P. Barden, R. W. Stander, and the resident staff of the department of obstetrics and gynecology, and Drs. R. Rohn, W. Bond and members of the department of hematology for their help in the management of this patient and preparation of this paper.

REFERENCES

1. Von-Willebrand, E. A.: Hereditare pseudohemofilia, *Finska lak-solesk handl* 68:87, 1926.
2. Quick, A. J.: *Hemorrhagic Diseases*, Lea and Febiger, Philadelphia, 1957.
3. Estren, S., Medal, L. S., Dameskek, W.: Pseudohemophilia, *Blood* 1:504, 1946.
4. Quick, A. J.: Menstruation in hereditary bleeding disorders, *Obstet. Gynec.* 28:37, 1966.
5. MacFarlane, R. G.: Critical review the mechanism of hemostasis, *Quart. J. Med.* 10:1, 1941.
6. Perkins, W.: Pseudohemophilia: A case study, *Blood* 1:497, 1946.
7. Jamia, M. A., Vierra, C. B., Lichtenstein, R., Riberio Laite, M. O.: Capilaropatia constitucional Forma de Von-Willebrand e forma capilar simples, *Rev. Hosp. Clin.* 7:12, 1952.
8. Imerslund, O.: Familial haemorrhagic diatheses with prolonged bleeding time (pseudohemophilia, thrombopathies), *Acta paediat.* 38:311, 1949.
9. Von-Willebrand, E. A., Jurgens, R.: Ueber eine neue Bluterkrankheit die Konstitutionelle Thrombopathie, *Klin. Wchnschr.* 12:414, 1933.
10. Glanzmann, E.: Sporadische konstitutionelle Thrombopathie, *Schwiz. med. Wchnschr.* 76:1014, 1946.
11. Kusel, H., Lohr, K.: Beitrag zur Thrombopathie vom Typ Von-Willebrand-Jurgens, *Auztl. Wchnschr.* 6:777, 1951.
12. DeVries, A., Schafrir, E., Efrati, P., Shamir, Z.: Thrombocytopathic purpura with normal prothrombin consumption, *Blood* 8:1000, 1953.
13. Hewlett, J. S., Haden, R. L.: Hereditary pseudohemophilia: Report of four cases, *Cleve. Clin. Quart.* 15:118, 1948.
14. Jacobson, B. M.: Effects of cortisone and corticotropin on prolonged bleeding time. Treatment in certain hemorrhagic state (pseudohemophilia), *Arch. Int. Med.* 92:471, 1953.
15. Etcheverry, R., France, S. O.: Pseudohemofilia, *Rev. med. de Chile* 76:331, 1948.
16. Grasso, E.: Su un caso di Trombocitopatia contituzionale sporadia, *Mineiva pediat.* 4:36, 1952.
17. Wendt, W. P., LaFond, D. J.: Pseudohemophilia (Von-Willebrand's disease) in Obstetrics and Gynecology, *Am. J. Obstet. Gynec.* 83:207, 1962.
18. Nillson, I.M., Blomback, M., Blomback, B.: Von-Willebrand's Disease in Sweden. Its pathogenesis and treatment, *Acta med. Scandinav.* 164:263, 1959.
19. Riggs, R., Matthews, J.: The treatment of hemorrhage in Von-Willebrand's disease and the blood level of Factor VIII (AHG), *Brit. J. Heam.* 9:203, 1963.
20. Buchanan, J. C., Leavell, B. S.: Pseudohemophilia: Report of 13 new cases and statistical review of previously reported cases, *Ann. Int. Med.* 44:241, 1956.
21. Bernard, J., Beaumont, J. L., Chauteyon, M. C.: Etude de la Fonction thromboplastique des plaquettes dans deux cas de dystrophie thrombocytaire hemorragipare congenitale, *Rev. d'hemat.* 8:20, 1953.
22. Levy, L.: Non-specific hereditary hemorrhagic diatheses: A report of a family of bleeders, *Ann. Int. Med.* 27:96, 1947.
23. LeLong, M., Soulier, J. P.: Sur une maladie hemorragique constitutionnelle caracteruee par l'allongement isole du temps de saignement, *Rev. d'hemat.* 5:13, 1950.
24. Kuchel, O., Soyka, O.: Pripad rodinneho vyskytu thrombopathie Willebrandovy-Jurgenosy, *Lek. listy* 8:201, 1953.
25. Strauss, H. S., Diamond, L. K.: Elevation of Factor VIII (antihemophilic factor) during pregnancy in normal persons and in a patient with Von-Willebrand's disease, *New Eng. J. Med.* 269:1251, 1963.
26. Singer, K., Ramot, B.: Pseudohemophilia Type B, *Arch. Int. Med.* 97:715, 1956.

**A breakthrough
in the control of pain**

Talwin[®]
brand of
pentazocine
(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**



A breakthrough in the control of pain

Talwin[®]
brand of
pentazocine
(as lactate)

**a potent injectable non-narcotic—
may be used in place of morphine
and other narcotic analgesics**

**Talwin 30 mg. relieves pain
usually as quickly and
effectively as morphine 10 mg.***

whatever the intensity of the pain

whatever the cause of the pain

whatever the site[†] of the pain

whatever the chronicity of the pain

whatever the age^{††} of the patient

without the liability of narcotics

**without the development of tolerance on
prolonged use**

**with less risk of severe respiratory
depression than with morphine**

with less constipation

with less urinary retention

Clinical experience of more than 150 investigators with over 12,000 patients given varying dosages of Talwin shows that this potent injectable analgesic is not a narcotic.

Talwin has less risk of severe respiratory depression, urinary retention, and constipation than morphine—a great boon for postsurgical patients.

Talwin produces less nausea, vomiting and diaphoresis than meperidine.

Constipation and urinary retention are seldom a problem with Talwin.

Very rarely do hallucinations or disorientation occur (0.1% each).

No significant hepatic, renal, hematopoietic or neurologic disturbances have been reported.

Talwin is well tolerated even by the aged or very ill patients.

Used during active labor, its tolerance by the mother and newborn is comparable to meperidine's. As with all new drugs, Talwin should be used with caution in pregnant women and in women delivering premature infants.

Tolerance to the analgesic effect of Talwin has not developed with prolonged use.

Talwin gives significant relief of pain in from 15 to 20 minutes following I.M. or S.C. injection.

Talwin relieves pain usually for 3 hours or longer with a single injection; however, the duration may sometimes be less than with morphine.

*Its duration of action may sometimes be less than that of morphine.

†Should not be used for patients with increased intracranial pressure, head injury or pathologic brain conditions.

††Until sufficient experience is gained, Talwin should not be administered to children under 12 years of

**86 per cent of medical and
surgical patients obtained
excellent to good relief with
Talwin 30 mg. administered
parenterally**

Talwin

brand of pentazocine (as lactate)

used for pain of all types

Talwin has a wide range of usefulness in surgery

Types of surgical use	Number of patients	Efficacy					
		% Exc.	% Good	Exc. + Good	% Fair	% Poor	
• Preoperative	118	31	52	83%	15	2	
• Postoperative	914	58	28	86%	8	6	
• Pre- and postoperative	12	75	17	92%	0	8	
• Minor surgery	33	30	39	69%	0	31	
• Traumatic	14	64	29	93%	7	0	
• Dental	33	67	24	91%	3	6	

Total patients.....1124

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of surgical use in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.
*High incidence of poor results in minor surgery is due primarily to one study involving change of burn dressings in children; 9 of 19 patients obtained poor results with dose used.

Talwin relieves all types of pain in acute and chronic medical disorders

Type of medical pain	Number of patients	Percentage of relief					
		Excellent	Good	Exc. + Good	Fair	Poor	
• Malignancy, pain in	161	44	37	81%	8	11	
• Orthopedic; see also "Arthritis"	111	53	38	91%	5	4	
• Cardiovascular pain; see also "Miscellaneous medical"	96	59	27	86%	6	7	
• Genitourinary pain	83	42	33	75%	16	10	
• Arthritis	76	33	51	84%	12	4	
• Gynecologic pain	35	57	34	91%	6	3	
• Cephalgia	21	45	41	86%	9	5	
• Gastrointestinal pain	19	89	5	94%	0	5	
• Chest, including <ul style="list-style-type: none">• Pleurisy• Pulmonary embolism and infarct• Lung abscess	12	83	17	100%	0	0	
• Miscellaneous medical, including <ul style="list-style-type: none">• Peripheral vascular disease• Thrombophlebitis• Cervical root pain• Facial neuralgia• Syringomyelia• Burns	108	50	39	89%	9	2	

Total patients.....722

Efficacy of 30 mg. Talwin I.M. and S.C. as related to types of medical pain in a cooperative study

Data in files of Department of Medical Research, Winthrop Laboratories.

See next page for additional product information

Talwin relieves pain as quickly as morphine

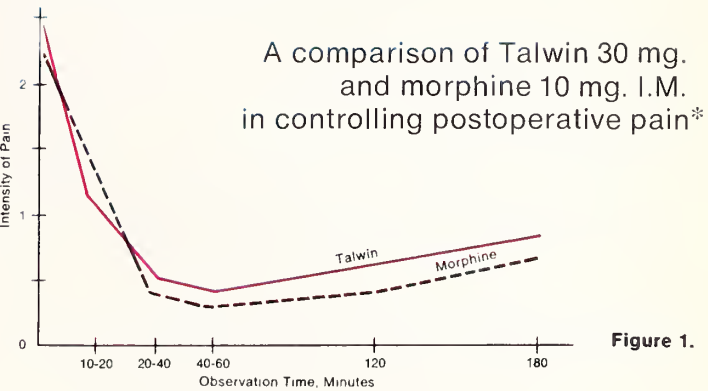
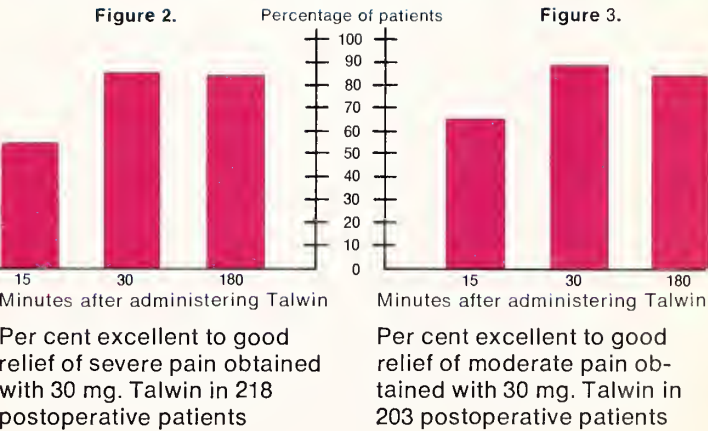


Figure 1.

Talwin 30 mg. proved equivalent to morphine 10 mg. in overall analgesic efficacy. During the early post-medication period (up to 40 minutes after drug injection), Talwin was superior in effect to morphine.

After observation periods ranging from 40 to 180 minutes there was no difference between the drugs in their effect on intensity. There were 141 and 119 complete patient records for Talwin and morphine, respectively, in this double-blind study. Other clinical investigators, studying duration, state that relief with Talwin may be obtained for up to three hours or longer, a period sometimes less than morphine's.

Talwin is as effective for severe pain (Fig. 2)† as for moderate pain (Fig. 3)†



Per cent excellent to good relief of severe pain obtained with 30 mg. Talwin in 218 postoperative patients

Per cent excellent to good relief of moderate pain obtained with 30 mg. Talwin in 203 postoperative patients

Talwin does not require a narcotics prescription or narcotics records

The World Health Organization Expert Committee on Dependence-Producing Drugs concluded that "...there was no need at this time for narcotics control of pentazocine [Talwin] internationally or nationally."

*Storer, E. H.: Data in the files of the Sterling-Winthrop Research Institute.

†Cooperative study, data in the files of the Department of Medical Research, Winthrop Laboratories.

]World Health Organization Technical Report Series, No. 343, 1966, p. 6.

A breakthrough in the control of pain

Talwin®

brand of
pentazocine
(as lactate)

a potent injectable non-narcotic— may be used in place of morphine and other narcotic analgesics

Contraindications: *Increased Intracranial Pressure, Head Injury, or Pathologic Brain Conditions in which clouding of sensorium is undesirable.* Talwin (brand of pentazocine) should not be administered in these cases, since drug-induced sedation, dizziness, nausea, or respiratory depression could be misleading.

Precautions: *Pregnancy.* No teratogenic or embryotoxic effects attributable to the use of Talwin have been seen in extensive reproductive studies in animals; however, like all new drugs, Talwin should be given with caution to pregnant women. A large number of patients in labor have received the drug with no adverse reactions other than those that occur with commonly used strong analgesics. However, as with other strong analgesics, Talwin should be used with caution in women delivering premature infants.

Ambulatory Patients. Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards.

Certain Respiratory Conditions. The possibility that Talwin (brand of pentazocine) may cause respiratory depression should be considered in treatment of patients with bronchial asthma. Talwin should be administered only with caution and in low dosage to patients with respiratory depression (e.g., from other medication, uremia, or severe infection), obstructive respiratory conditions, or cyanosis.

Patients Dependent on Narcotics. Because Talwin is a narcotic-antagonist, patients dependent on narcotics and receiving Talwin may occasionally experience certain withdrawal symptoms. Talwin should be given with special caution to such patients. It has been observed that some patients previously given narcotic-analgesics for one month or longer had mild withdrawal symptoms when the drug was replaced with the analgesic, Talwin. After a short period of adjustment the subjects were usually able and willing to continue taking Talwin, and relief of pain was satisfactory.

Nonaddicted Patients Receiving Narcotics. Symptoms believed to be indicative of antagonism to the opiate may be observed rarely with administration of Talwin to patients receiving opiates for a short time. Intolerance or untoward reactions are seldom observed after administration of Talwin to patients who have received single doses or who have had limited exposure to narcotics.

Impaired Renal or Hepatic Function. Although laboratory tests have not indicated that Talwin (brand of pentazocine) causes or increases renal or hepatic impairment, the drug should be administered with caution to patients with such impairment. Extensive liver disease appears to predispose to greater side effects (e.g., marked apprehension, anxiety, dizziness, sleepiness) from the usual clinical dose, and may be the result of decreased metabolism of the drug by the liver.

Myocardial Infarction. As with all drugs, Talwin (brand of pentazocine) should be used with caution in patients with myocardial infarction who have nausea or vomiting.

Biliary Surgery. Until further experience is gained with the effects of Talwin on the sphincter of Oddi, the drug should be used with caution in patients about to undergo surgery of the biliary tract.

Adverse Effects: Talwin is relatively free from the undesirable side effects associated with morphine, such as constipation, urinary retention, or severe respiratory depression. Furthermore, Talwin produces less nausea, vomiting, and diaphoresis than meperidine.

In over 12,000 patients who received Talwin intramuscularly, subcutaneously, or intravenously, nausea, the most frequent adverse effect, occurred in approximately 5.0 per cent. In decreasing order of occurrence were vertigo, dizziness or lightheadedness; vomiting; and euphoria. Respiratory depression was reported as an adverse reaction in 1.0 per cent.

The incidence of each of the other adverse effects was well below 1.0 per cent: constipation, circulatory depression, diaphoresis, urinary retention, alteration in mood (nervousness, apprehension, depression, floating feeling), hypertension, sting on injection, headache, dry mouth, flushed skin including plethora, altered uterine contractions during labor, dermatitis including pruritus, dreams, paresthesia, and dyspnea occurred rarely after administration of Talwin (brand of pentazocine). Furthermore, each of the following adverse reactions occurred in less than 0.1 per cent: tachycardia, visual disturbance (blurred vision, diplopia and nystagmus), hallucinations, disorientation, weakness or faintness, muscle tremor, chills, allergic reactions including edema of the face, taste alteration, insomnia, diarrhea, cramps, and miosis; laryngospasm in one patient.

Talwin has not produced severe respiratory embarrassment in adults (never apnea), even with large amounts. A small number of newborn infants whose mothers received Talwin during labor had transient apnea. The incidence of temporary diminution in the rate or strength of uterine contractions is low after administration of Talwin, similar to that following meperidine hydrochloride. (In reporting no interference with normal labor in patients receiving Talwin, one investigator further stated that the drug may increase uterine activity.) Generally, no significant fetal heart rate change occurs.

Laboratory tests of blood and of liver and kidney functions have revealed no significant abnormalities. A minimum and probably insignificant increase in the per cent of eosinophils in peripheral blood counts and bone marrow occurred occasionally.

Talwin is well tolerated by patients with diabetes mellitus, and no changes in insulin requirements have been observed.

Dosage and Administration: Adults, Excluding Patients in Labor. Average recommended single parenteral dose is 30 mg., by intramuscular, subcutaneous, or intravenous route; may be repeated every three to four hours. Pain has been relieved in most patients with not more than three doses daily. Infrequently, selected patients have received single doses as high as 60 mg.

Patients in Labor. A single, intramuscular 30 mg. dose has been most commonly administered. An intravenous 20 mg. dose has given adequate pain relief to some patients in labor when contractions become regular, and this dose may be given two or three times at two- to three-hour intervals, as needed.

Children Under 12 Years of Age. Since clinical experience in children under twelve years of age is limited, the use of Talwin (brand of pentazocine) in this age group is not recommended.

Duration of Therapy. Patients with chronic pain who received Talwin for prolonged periods (e.g., over 300 days) experienced no withdrawal symptoms even when administration was stopped abruptly; furthermore, there was no tolerance to the analgesic effect.

CAUTION. Talwin should not be mixed in the same syringe with soluble barbiturates because precipitation will occur.

Treatment of Overdosage or Respiratory Depression. Talwin has not produced apnea or severe respiratory embarrassment in adults, even in large doses. Occasionally, however, moderate respiratory depression may occur. Means of maintaining proper oxygenation should be available in case of overdosage or respiratory depression, and methylphenidate (Ritalin®) should be administered parenterally. The usual narcotic-antagonists, such as nalorphine, are not effective respiratory stimulants for depression due to Talwin.

How Supplied: Ampuls of 1 ml., containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base and 2.8 mg. sodium chloride, in Water for Injection. Boxes of 10, 25, and 100.

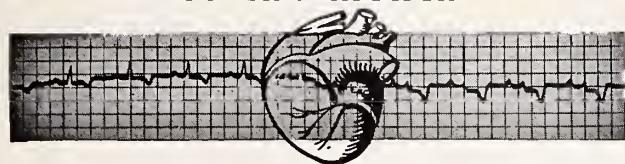
Multiple dose vials of 10 ml., each 1 ml. containing Talwin® (pentazocine) as lactate equivalent to 30 mg. base, 2 mg. acetone sodium bisulfite, 1.5 mg. sodium chloride, and 1 mg. methylparaben as preservative, in Water for Injection. Boxes of 1.

The pH of Talwin solutions is adjusted between 4 and 5 with lactic acid and sodium hydroxide.



Winthrop Laboratories, New York, N. Y. 10016

Electrocardiogram of the month



Presented as a regular feature of *The JOURNAL*, *Electrocardiogram of the Month* is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

Double Tachycardia in Emphysema

CHARLES FISCH, M.D.
Indianapolis

CLINICAL experience has shown that patients with far advanced pulmonary emphysema frequently develop arrhythmias. Whether this increased incidence is due to hypoxia, acidosis, hypercarbia, electrolyte disturbance, unusual sensitivity to digitalis or a combination of factors remains to be settled.

Figure 1 is a rare example of a complex arrhythmia, namely one of a double tachycardia in a patient with severe emphysema. The upper part

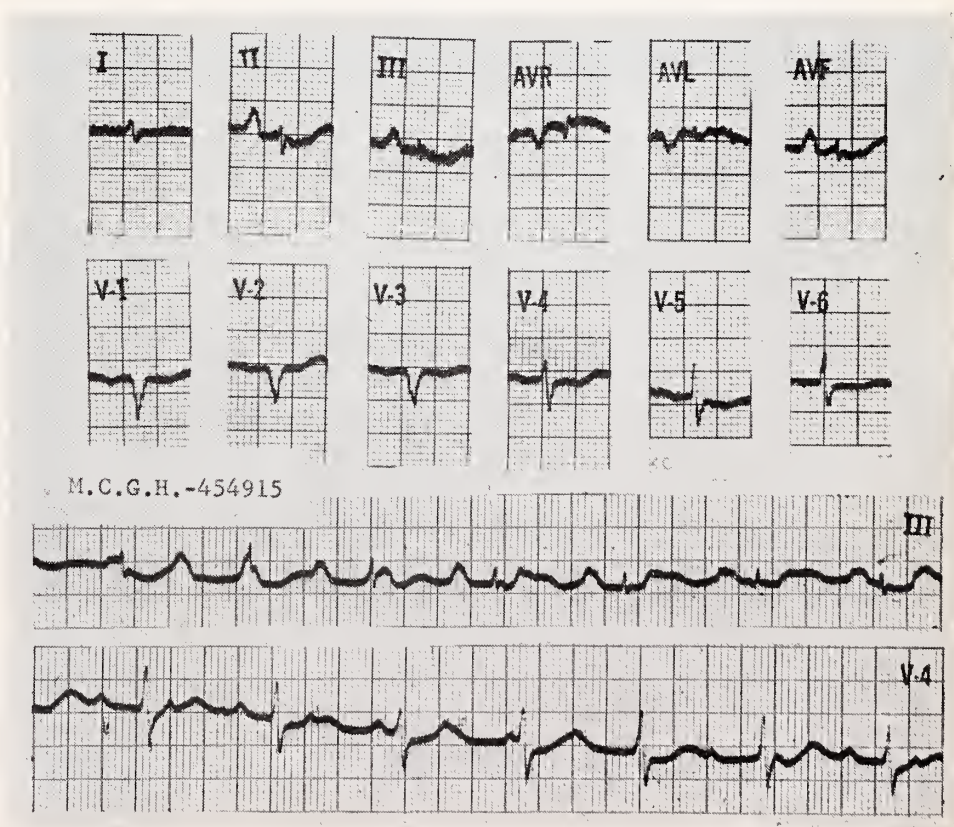
of the tracing was described in the May, 1967, ECG of the Month and demonstrates classical findings of emphysema.

The two rhythm strips demonstrate an atrial rate of 140. The P waves are of different morphology than the respective P waves recorded during sinus rhythm and shown above, thus ectopic in origin. The ventricular rhythm is absolutely regular at a rate which differs from that of the P

waves, namely 80 per minute. The QRS is of normal morphology indicating A-V nodal (junctional) origin. There is a lack of any temporal relationship between P and QRS complexes denoting A-V dissociation with an independent atrial and nodal tachycardia. Since the atrial rate exceeds that of the ventricular, some degree of A-V block must be present, otherwise the ventricles would be captured and controlled by the atria. ◀

FIGURE 1

THE upper two rows show a complete tracing of a patient with chronic pulmonary emphysema. The lower two strips demonstrate double tachycardia (for details see text).



X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Superimposition Cystography

ERICH K. LANG, M.D.
Indianapolis

A 62-year-old white male was admitted for assessment of recurrent hematuria. Cystoscopy revealed the presence of a papillary tumor in the left dome of the bladder. The tumor was resected, and the base fulgerated with electrocautery. Histologic examination of the resected papilloma revealed a grade I carcinoma. A muscle biopsy obtained from the base of the tumor showed no evidence of infiltration. An intravenous pyelogram revealed the upper urinary tracts to be unremarkable.

Further radiographic evaluation of the bladder wall was desired. A superimposition cystogram demonstrated normal distensibility of the dome and the right lateral bladder wall, but suggested fixation in the area of the left trigone and in the base and floor of the bladder on the left side (Figure 1). The lack of distensibility and motion of this segment of the bladder suggested fixation by either inflammatory or neoplastic disease. Re-biopsy of the left base of the bladder by serial deep muscle biopsies revealed the presence of infiltrative tumor. In view of the infiltrative nature of the tumor, the patient was then subjected to cobalt 60 therapy, and a total dosage of 6,000 rep was delivered to the bladder via three intersecting ports.

Technic

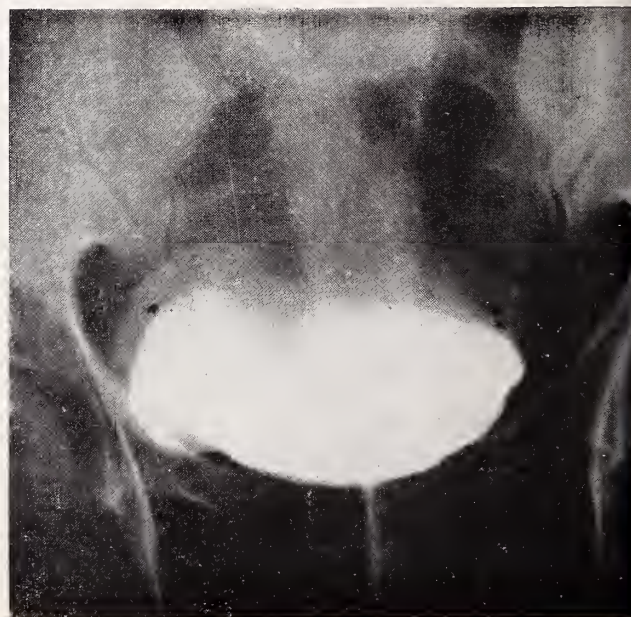
Superimposition cystography is designed for the comparative assessment of motility and distensibility of various segments of the bladder. The bladder is distended with approximately 50ccs. of undiluted Skiodan. The first roentgenographic exposure is then obtained under conditions of maximal expiration. Subsequent to that, the contrast material in the bladder is diluted with two separate additions of 50ccs. of saline. After each injection, another roentgenographic exposure is superimposed on the same film. The patient is to remain in the same position, and the exposure is performed again under conditions of

maximal expiration. The resulting superimposed images allow assessment of distensibility of various segments of the bladder wall, and comparison of the motility of one segment to the other. The exposure factors for a satisfactory roentgenogram are critical.

The kilovoltage should not be varied for the exposures, and is determined on basis of standard tables of measurements for the respective patient. The appropriate milliamperes second exposure rate for each exposure is determined on the following principle: 50% of the milliamperes second exposure rate applicable to this area and this size patient is utilized.

FIGURE 1

A superimposition cystogram demonstrates a significant lack of distensibility of the left inferolateral bladder wall. A slight lag in the motion of the left superolateral bladder wall may well be secondary to fulgeration of the base of the previously resected papilloma. The lack of distensibility of the inferolateral bladder wall, and lack of motion of the trigone area, however, suggests fixation. Subsequent deep muscle biopsy confirmed the presence of an infiltrative tumor.



* Radiologist, Methodist Hospital, Indianapolis 46207.

ized for the first exposure; 33% of the calculated exposure rate is utilized for the second and third exposures. Summation effect of roentgenographic film subjected to multiple exposures necessitates an increase of the overall milliamperes second exposure rate. Progressive dilution of the contrast material in the bladder necessitates the progressive decrease in the exposure rate, to cast a shadow dense enough for optimal interpretation. It is, of course, mandatory that the patient remain in the same position, and that each exposure is made under

conditions of maximal expiration to allow a true superimposition and alignment of structures.

Comments

Superimposition cystography offers a simple method for the assessment of motility and distensibility of various segments of the bladder. Lack of uniform expansion and lack of motility reflects fixation of the wall of the bladder by either intrinsic or extrinsic inflammatory or neoplastic disease. It is emphasized that a further differentiation between neoplas-

tic and inflammatory disease is not possible by this method. Even fibrosis secondary to fulgeration of the base of a non-invasive tumor may often result in lack of distensibility of this segment of the bladder. This technique is, therefore, advocated as a screening method only, to be complemented by the old standby method of cystoscopy, deep muscle biopsy, bimanual examination of the bladder, arteriography, and endo- and perivesical gas studies. ◀

I.U. School of Medicine Postgraduate Courses (Division of Postgraduate Medical Education)

November 1 — Emotional Problems in General Hospital Practice, to be held at VA Hospital, Marion County, Indiana University Medical Center.

November 7 — Psychiatry in Everyday Practice, to be held at St. Vincent's Hospital, Indianapolis.

November 8 — Advances in Renal Disease Management, to be held at the Indiana University Medical Center.

November 8 — Emotional Problems in General Hospital Practice, to be held at Home Hospital, Lafayette.

November 14 — Psychiatry in Everyday Practice, to be held at St. Vincent's Hospital, Indianapolis.

November 15 — Emotional Problems in General Hospital Practice, to be held at Home Hospital, Lafayette.

November 29 — Common Psychiatric Disorders, to be held at St. Francis Hospital, Indianapolis.

The Cancer You View

PAUL V. EVANS, M.D.

LAURENCE H. BATES, M.D.

Indianapolis*

Edited by

Edwin E. Pontius, M.D.

Indianapolis*



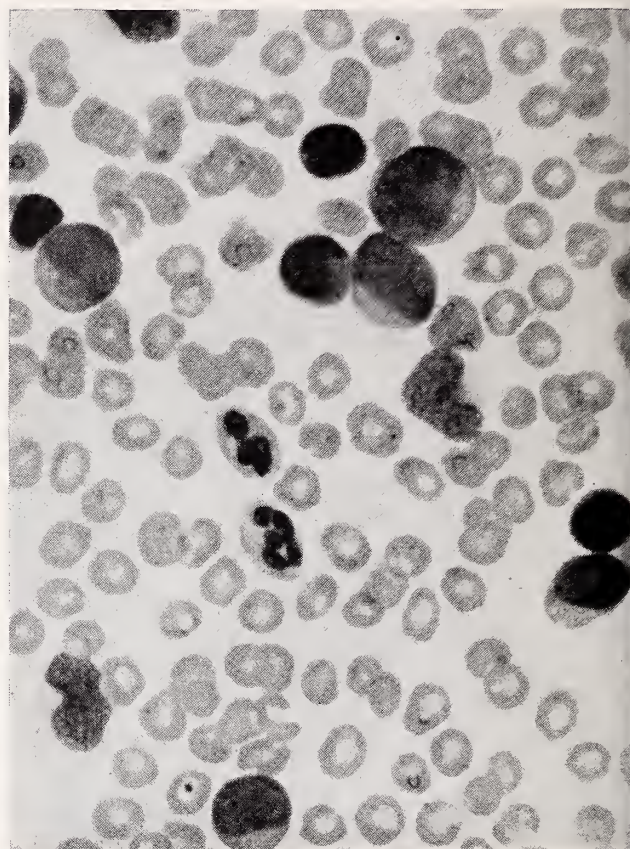
THREE days prior to admission, a 10-year-old white male developed an acute febrile illness with sore throat, bleeding gums, ecchymoses over the lower extremities, buttocks, abdomen and chest. Physical examination revealed petechiae over buccal mucosa and tonsils, and ecchymoses as indicated above. A slight cervical lymphadenopathy was present. Heart and lungs were considered normal and the liver was not palpable. The spleen was slightly palpable.

Laboratory data: Red blood count, 3,500,000; hemoglobin 9.6 gms.; hematocrit 29; white blood count, 30,000; coagulation time, 6 minutes; bleeding time, 11 minutes; and indirect platelet count, 51,000. The photomicrograph shows a typical field of the peripheral blood smear.

What differential diagnosis would you consider?

* From the Department of Pathology, Methodist Hospital of Indiana, Inc., Indianapolis, Ind. 46207.

Supported in part by a grant from the American Cancer Society, Indiana Division, Inc.



What is your diagnosis?

Any further diagnostic procedures?

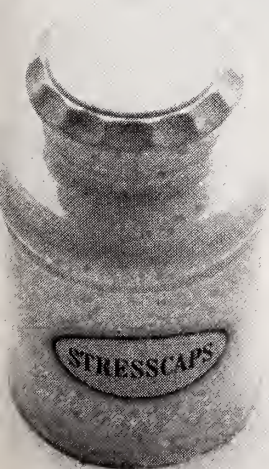
What therapy should be considered?

For diagnosis and discussion, please see page 1430.



following infection

B and C vitamins are therapy: STRESSCAPS B and C vitamins in therapeutic amounts...help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS capsules.



Stresscaps[®]

Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (as Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

Flat Feet, Plantar Warts and Corns

JOHN A. CRAWFORD, M.D.
Indianapolis

THE problem of flat feet begins early in life in our present day world, since mothers hear on every hand of the availability and advantages of early diagnosis and early correction of deformities and growth disturbances of childhood. Regardless of the relatively little importance of the subject to the busy physician, parents in general appear to exhibit great concern over the state of concavity or convexity of their offspring's plantar surfaces.

The problem can begin in earnest at birth with the appearance of the calcaneo valgus foot with its muscle imbalance, inflexible joint structures and generally narrow, weak construction. This type of foot, if allowed to go uncorrected, can lead to serious deformity and disability with continuation of a rigid, painful, weak foot. Correction can be undertaken at once, with the use of plaster splints, Denis Browne bars and passive exercise and manipulation.

There are all degrees of this deformity and certainly it deserves early attention. When stimulated by stroking or tickling, a foot of this type shows only eversion combined with dorsiflexion and cannot be made to draw into inversion and plantar flexion, thus demonstrating a muscle imbalance. These feet, when corrected early, have a good chance to become flexible and strong.

More common by far is the flat foot

which becomes apparent on weight-bearing and may be noticed as soon as the child begins to pull up to a standing position. Here the foot is generally more flexible, and on stimulation of the inner border of the foot by light touch or tickling, shows effective action of the invertors and plantar flexors. The flat foot, when hanging at rest, may show a good longitudinal arch which disappears on weight-bearing, but may reappear in varying degree when the child is persuaded to rise on tiptoe. If, on rising on tiptoe, the longitudinal arch appears and the heel comes to a neutral or inverted (varus) position, I would classify the foot as flexible and strong and would expect it to give no trouble in the future.

Inner Heel Wedges

Even a foot such as this, however, might benefit from an $\frac{1}{8}$ inch inner heel wedge, after walking age is attained, in order to relieve ankle valgus and knee strain. If the foot appears "flat" and everted when hanging at rest and still appears flat and demonstrates a valgus position of the heel even when standing on tiptoe, then I think it is structurally and hereditarily weak and may well be painful to some degree in later life. Even three and four-year-olds are sometimes relieved of "leg ache" and/or "night cramps" by support in the shoe. If the foot also shows tightness

of the heel cords, demonstrated by attempting dorsiflexion of the foot with the heel forcibly held in neutral or varus position, then I think some degree of trouble is certain and the foot may actually grow worse in appearance and function with increasing years and weight.

One frequently sees a weak flat foot coupled with a potbelly, flared ribs and generally soft, weak flaccid muscles. These babies often improve with age and develop a stronger foot as their muscle strength and tone increases. Such a state of dystonia however, can persist as a definite neuromuscular disorder.

Coupled with flat feet, one frequently sees knock knee, and what is helpful for one is also helpful for the other. The fat, flat footed baby who stands and walks early is undoubtedly putting a knock knee strain on his knee and should have that strain relieved by the use of inner heel wedges.

Types of Correction

In regard to types of correction, I see little use in the rigid shank, heavy stiff sole and stiff, long inner counter or "inner arch cookie" of many so-called corrective shoes. Any industrious toddler will either break these shoes down with startling ease or quite sensibly sit down and remove them because they hurt his feet. The "inner arch cookie" flattens out quickly, the bottom of the foot is

reddened, sweaty and tender — and still flat. I think a flexible shanked shoe, with an $\frac{1}{8}$ inch or $\frac{3}{16}$ inch inner heel wedge and as the foot grows longer, a Thomas heel, is more sensible, more comfortable and more apt to stay on the foot. The heel wedge influences the flexible sole so that in turn, ankle valgus can be influenced. Pronation of the forefoot is allowed by the flexible sole. The elongated inner borders of the Thomas heel afford all the effective support one can count on under the sustentaculum tali and holds up better than the arch cookie.

In older children, the flat foot which can break a steel Whitman plate is likely to be little influenced by a long stiff inner counter and one must tell the parents of the child that the aim is not correction of appearance but support and improvement of mechanics if possible. Actually many infantile flat feet do improve in appearance, but the very weak or stiff flat foot does not develop a longitudinal arch and the strong flexible flat foot, of which there are many, does not need one.

The Facts of Feet

In adults, the flat foot problem is complicated by weight, increasing muscular weakness, arthritic change and vascular disorders. Many a good foot becomes painful when abused by excessive weight; and a valgus heel and knock knee which withstood the onslaught of active youthful years, aided by powerful muscles and resilient joint structures, succumbs to increasing weight and the plodding advance of the years.

The post office worker who stands and sorts mail for eight hours a night and then augments his income by selling kitchen ware door to door, has to be told that human feet can endure just so much. Man is the only animal who doesn't have sense enough to lie down when he is tired of standing. Adult flat feet may also be strong and flexible, in which case they give little or no trouble. However, one sees the

rigid flat foot with bulging of the inner border of the foot, various degrees of eversion and abduction of the forefoot, a reddened, thin sweaty skin and tenderness and pain in ligamentous structures and muscles. Such a foot needs careful fitting of a proper shoe.

Rubber or "crepe soled" shoes only aggravate these feet. They promote sweating and further macerate the already tender skin. The soft yielding sole is alright for the sod of the golf green but is poor protection from the hard, rough surfaces which modern man walks on. A leather sole is still the best type of shoe sole and many adult feet benefit from the double thick leather sole with a flexible shank construction, or with the steel shank withdrawn, and with the addition of a Thomas heel and inner heel wedge. Even men are frequently guilty of wearing shoes far too narrow, and the dictum that the widest part of the foot must fit in the widest part of the shoe sounds almost inane but must be oft repeated in teaching patients the facts of feet.

Frequently one sees the patient who complains of soreness and pain in the region of the first metatarsal and along the inner side of the foot and heel. Questioning reveals that the patient is wearing a longer shoe than he used to wear and examination reveals real tenderness in the plantar fascia on pressure or stretching. This is the elongating flat foot which is actually losing its longitudinal arch and becoming longer and more pronated. This is seen in the third and fourth decade usually. This foot too will be benefited by a Thomas heel and a metatarsal bar. Here the "comma" bar is also useful.

The spastic or spasmodic flat foot is a subject in itself to be dealt with later.

The Flat Footed Female

What to do with woman? First, a proposition. There are differences between the sexes, but feet are not among them. Our idols have feet of

the same mortal clay as mere man. A woman spends years learning to walk in high heels but is not willing to spend days learning to walk without them. The fact that flat feet are rarely troublesome in themselves is attested to by the fact that we see 10 women to one man with foot trouble and that most female foot trouble is from the corns of clawed toes and the calluses under cramped metatarsal heads. Granted one sees the stiff, thin, bruised, painful flat foot, but until we can persuade the woman to wear a flat heeled oxford type of shoe — preferably with a leather sole and held on by ties — we can do little toward relieving her distress. Then only can the Thomas heel and metatarsal bar be effective and no wedge, pad, arch support, bar or other device can be effective in a high heeled shoe.

Occasionally the rigid, painful flat foot will answer only to surgical measures and here the triple arthrodesis of subtalar, talonavicular and calcaneocuboid joints is the soundest measure. A foot such as this is rare and will usually demonstrate arthritic changes. Sometimes medical treatment of a suspected mixed rheumatoid and degenerative arthritis will give great relief to the painful foot and many times salicylates or other anti-inflammatory drugs solve the problem.

Gouty arthritis deserves to be considered too, and a trial of Colchicine or Benemid for a pair of warm, reddened, tender, chronically painful feet is certainly justified. The fact that the ailment is chronic and not acute does not rule out gouty arthritis.

Plantar Warts

What, where and when is a plantar wart? In the first place — warts are warts, and warts on the sole of the foot are plantar warts. When the papilloma is on a non-weight bearing surface, its warty nature is more apparent although most warts on the sole even on non-weight bearing points are flattened and pushed into the surrounding skin. When a wart

is on a weight-bearing surface it is definitely flattened and usually covered with a surrounding and overlying layer of callus to the point of being nearly unrecognizable. However, the exquisite tenderness of its central area, the appearance of blackened punctate areas representing the papillae of the wart and the occurrence in an unusual location for an ordinary callus help to differentiate it. I am always distressed to see an adult with a plantar wart or warts because I know of no single uniformly effective treatment for the ailment.

The "crops" of warts seen in youngsters are seldom a problem. because protection from weight-bearing with a cut-out adhesive felt pad relieves their distress and usually the warts will finally disappear. Vigorous

destructive treatment is to be avoided and the evils of x-ray far outweigh its therapeutic good. I have usually outwaited these crops of warts and have seen them disappear with little or no treatment.

In the adult, the secondary callus formation and recurrent intractable nature of the papilloma itself makes the problem worse. Avoidance of pressure is of first importance and here metatarsal bars, felt pads and hollowed out shoe soles are helpful. Injection with "Keramin", a proprietary Vitamin A preparation, has been strangely successful but I have no really scientific evidence to support its use. I remember injecting one of several warts on one foot only to have the whole crop disappear without any other treatment.

Every thickened callus is not a plantar wart and tough, thick, horny lesions under the metatarsal heads are probably calluses due to the response of the special skin of the sole to pressure from metatarsal heads. Even in the adult, I am fearful of destructive x-ray therapy and think its use should be avoided. Surgery frequently leaves scars which are more tender and troublesome than the original lesion. Conservative measures are in order. Sometimes the area surrounding the wart becomes acutely swollen, red-dened and painful. Here bed rest, hot soaks, paring of calluses and even antibiotics are advisable. ◀

321 Hume Mansur Bldg.
Indianapolis 46204

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

W. R. VanDenBosch, M.D.

David L. Evans, M.D.

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

J. Kenneth Cooke, M.D.

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

(Phone)

447-6404

447-9155

743-1809

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No *in vitro* test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'[®]

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT



BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

The full 1/4 grain of phenobarb in the formula
takes the nervous edge off the pain
...helps bring out the best in codeine



Phenaphen[®] with Codeine

the only leading compound
analgesic that **calms**
instead of caffeinates

Each capsule contains:

Phenobarbital (1/4 gr.) 16.2 mg.
(Warning: may be habit forming)
Aspirin (2 1/2 gr.) 162.0 mg.
Phenacetin (3 gr.) 194.0 mg.
Hyoscyamine sulfate 0.031 mg.
Codeine phosphate 1/4 gr. (No. 2),
1/2 gr. (No. 3), 1 gr. (No. 4)
(Warning: may be habit forming)

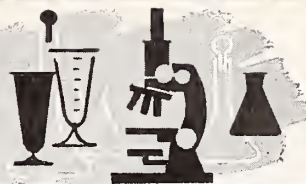
Contraindications: Hypersensitivity to any ingredient.

Precautions: As with all phenacetin-containing products, avoid excessive or prolonged use.

Side Effects: Side effects are uncommon — nausea, constipation, and drowsiness have been reported.

A. H. ROBINS CO., INC., Richmond, Va. 23220

A·H·ROBINS



This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.

Serum Enzymes and Myocardial Infarction

W. P. LOH, M.D.
Gary*

INCREASED serum enzymes offer great aids in the diagnosis of myocardial infarction. The following four enzymes are frequently measured for this purpose. Other enzymes mentioned in the literature offer less value.

1. *Glutamic-oxalacetic transaminase (GOT)* Normal range: 1-36 units.

$$\text{Glutamic acid} + \text{oxalacetic acid} \xrightleftharpoons{\text{GOT}} \text{aspartic acid} + \text{alpha-keto-glutaric acid}.$$
 The serum GOT level usually begins to rise in six to 12 hours, reaches a peak within 24 to 48 hours, and then subsides to normal level rapidly.¹ Its elevation may be missed if there is a two to three-day delay before the serum is tested.²

2. *Creatine phosphokinase (CPK)* Normal range: 0-12 units.

$$\text{Creatine} + \text{adenosine triphosphate} \xrightleftharpoons{\text{CPK}} \text{creatine phosphate} + \text{adenosine diphosphate}.$$
 CPK activity increases within three to five hours after a myocardial infarction and its increase is more short-lived than that of GOT. The CPK activity is slightly more specific but is less easily assayed because of its relative instability and some technical difficulties.

3. *Lactic dehydrogenase (LDH)* Normal range: 200-500 units.

$$\text{Pyruvic acid} \xrightleftharpoons{\text{LDH}} \text{lactic acid}.$$
 LDH activity increases more slowly and the increase

persists for a long duration up to 12 days. The enzyme activity is relatively stable in serum, but can be inhibited by an excess of a commonly used anticoagulant if plasma instead of serum is used for testing.

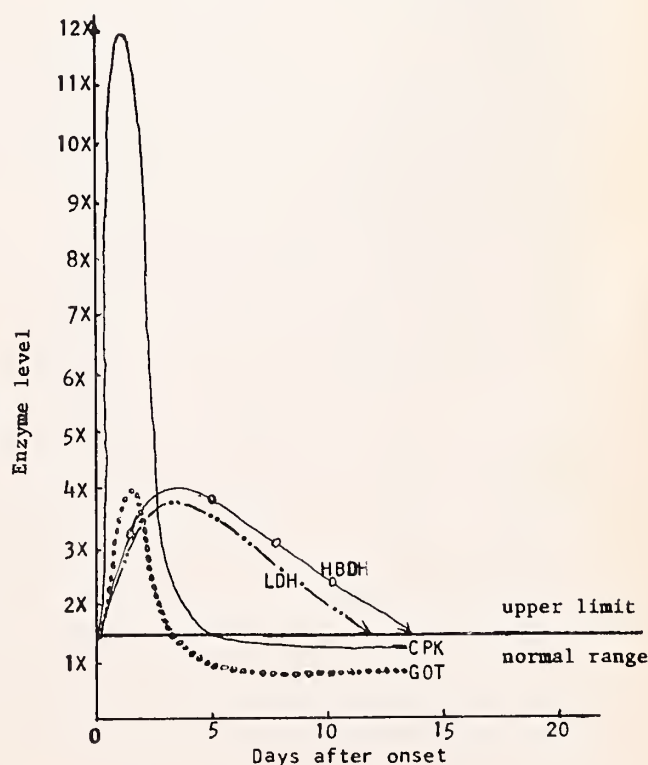
4. *Hydroxybutyric acid dehydrogenase (HBDH)* Normal range: 120-260 units.

$$\text{Alpha-oxybutyric acid} \xrightleftharpoons{\text{HBDH}} \text{alpha-OH butyric acid}.$$
 HBDH activity also increases slowly. The increase is slightly more rapid than that of LDH and can persist for a much longer duration — even up to 14 days.

Comment

1. After acute myocardial infarction, GOT and CPK increases are rapid and are of short duration. The LDH and HBDH increases are relatively slow and are of much longer duration (Figure 1). For this reason simultaneous assay of several enzymes, at least one demonstrating changes of short duration and one those of longer duration, offers more information than the assay of only one enzyme.^{3,4}

FIGURE 1
SCHEMATIC curves showing enzyme levels after acute myocardial infarction.



* Chief pathologist, Methodist Hospital of Gary, and associate professor of pathology, Chicago Medical School, Chicago.

2. These tests are most meaningful when assayed daily, for they often provide a pattern of increase or decrease in the enzyme activity. Such patterns are often needed in the differential diagnosis. In case of angina pectoris, serial determinations may show a slight and transient elevation of the GOT alone. Pulmonary infarction usually gives an increased LDH and a normal GOT.

3. Single instances of increased activity of the four enzymes have a

limited diagnostic usefulness because of their nonspecificity. Increased activity could be found when the skeletal muscle, liver, brain, lungs, kidneys or red cells are damaged. However, a specific test for myocardial infarction is available in determination of LDH-isoenzymes.

4. Serum showing absence of hemolysis is preferred for the enzyme assay.

REFERENCES

1. Harrison, T. R., et al: *Principles of In-*

ternal Medicine, Ed. 5, New York, McGraw-Hill Book Co., 1966, p. 836.

2. Amador, E., Franey, R. J., Massod, M. F.: Serum glutamic-oxaloacetic transaminase activity: Diagnostic accuracy of the revised spectrophotometric and the dinitrophenylhydrazine methods, *Clin. Chem.* 12:475, 1966.

3. Sheinin, J., Cohen, L.: Serum enzymes and diagnosis of acute myocardial infarction, *Postgrad. Med.* 36:594, 1964.

4. Cohen, L.: Contributions of serum enzymes and isoenzymes to the diagnosis of myocardial injury, *Modern Concepts Cardiovasc. Dis.* 36:43, 1967.

Carnage on Our Highways

Alcohol has been found to be a contributing factor in more than half of the fatal traffic accidents, according to independent surveys.

The alcohol connection was established through post-mortem studies of persons killed in accidents. The studies have been conducted in a number of states, and the results agree remarkably well.

A Travelers Insurance Companies spokesman said in an annual report on highway statistics, that each individual will have to make up his own mind about his personal drinking habits and driving a car. "Obviously," the spokesman added, "the driver enormously increases his chances of being in an accident—involving not only himself but others—when he drives after drinking. And the research on this subject shows clearly that he increases his risk with each additional drink."

Last year more than 52,500 persons were killed in highway accidents, an eight percent increase over 1965. Additionally, 4,400,000 persons were injured. Beyond the human suffering, the economic loss as a result of the traffic accident problem amounted to \$9.8 billion.

The Travelers report also showed that in 1966 more than 286,800 pedestrians became casualties—40% of the total deaths occurred on weekends—four out of five personal injury accidents occurred in clear weather on dry roads—and almost 32% of the drivers involved in fatal accidents were under 25 years of age.

"Every man, woman and child has a stake in the traffic safety problem. Each must do all in his or her power to eliminate the terrible carnage on our highways," the spokesman added.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*. A brief precautionary statement follows.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use cautiously, especially in the first trimester. **Note:** The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

**a stuffy nose
is no
laughing matter**

Ornade[®] Trademark

Each capsule contains 8 mg. of Teldrin[®] (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule[®] Capsules

brand of sustained release capsules

**each one can
give him all-day
or all-night relief**



Smith Kline & French Laboratories



Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Romsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46208.

Associate Editors: A. W. Covins, M.D., 221 South Sixth
Street, Terre Haute; Loll G. Montgomery, M.D.,
Boll Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:

Term Expires

Horold D. Lynch, M.D., Evansville	Dec. 31, 1967
Jene R. Bennett, M.D., South Bend	Dec. 31, 1967
Alvin J. Haley, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jack W. Hickmon, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Woggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Clinical Investigation: Why Make It More Difficult?

CLINICAL investigation tends to be more difficult under the new government policies and regulations, and may be so hampered in some instances as to lose its effectiveness.

Practitioners worry about the side-effects of the drugs they prescribe. Everyone should be worrying about the side-effects of government regulations in regard to the clinical testing of new drugs. Government regulations are necessary, just as drugs are necessary, but the side-effects of each are bothersome and in some cases dangerous. Regulations must be applied with great wisdom or they will do more harm than good.

A thoughtful editorial, under the above title, written by Dr. Wallace E. Herrell, Editor of *Internal Medicine Digest*, appeared in that journal's July issue. Dr. Herrell points out that there is a question as to whether or not the public's interest is better served by rigid controls or if, in fact, the public may be the loser because of the regulations.

He cites the case of an investigator who, "for three months, was refused permission to test, for a new purpose, a potentially life-saving drug which had already been used, without evi-

dence of toxicity, on half a million humans in other countries for a different purpose." Use of the drug in prevention of ventricular fibrillation was to be investigated. If such a drug should prove effective in preventing ventricular fibrillation, then surely many lives would be lost because of its delayed approval.

Regulations on informing patients who participate in clinical investigations may tend to invalidate the entire study. Even though the advantages of the double blind method are probably overemphasized, it is evident that, if half the patients are informed that they are receiving an inactive placebo, the results will be useless.

And, on the other hand, should regulations insist that the double blind technic be applied when a drug is being tested against a highly fatal condition and there is evidence that the drug may be able to save lives?

Dr. Herrell points out that morality is the necessary ingredient of all clinical investigation and that most investigators have it. Morality cannot be legislated; the investigator who has it does not need to have it furnished and the law cannot supply it for the man who doesn't possess it.

Dr. Herrell suggests that, since most good clinical research is done in medical institutions, all clinical in-

vestigation should be monitored by a research director or research committee of the hospital or medical school concerned.

He also has a remedy for the plight of the pharmaceutical industry which, while it is not directly concerned with clinical investigation, supports much of it financially and invests millions in the search for and development of new therapeutic entities. "If they [the industry] cannot function effectively because of ever-increasing government controls, then it is high time something be done to correct any inequities that now exist."

Dr. Herrell's conclusion is: "Finally, it is my belief that most individuals in clinical research and industry are men of good character and with a deep sense of moral and ethical responsibility. To be sure, there are a few who would not qualify by these standards, but I repeat that the Congress will never be able to write laws to eliminate this minority. Let the institutions and the individuals in the institutions in which the clinical research is to be done, as well as those in the pharmaceutical industry, police themselves."

Guest Editorials

Generic Equivalents

MUCH has been said, both pro

and con, with respect to generic equivalents in the drug field. For some reason, the term "generic" has become associated with the word "cheaper," in its connotation to the public. The U. S. Congress is presently conducting hearings on this particular subject and has heard reports and arguments from proponents of the "generic" prescribing philosophy. This philosophy would establish a regulation that all drugs paid for in whole or in part by the federal government must be prescribed under "generic" terminology.

One of the main reasons for such a regulation, argue the proponents, is that the federal government purchases drugs by generic names and such drugs are used in treatment given at the major military installations of the country, such as the Walter Reed Army Hospital, Bethesda Naval Hospital, and others.

In actual fact, however, this is not so. The Department of Defense, which buys drugs for all the armed services, buys them according to rigid, quality-oriented specifications. It conducts a most rigid inspection and testing program. It rejects many of the companies that ask to do business with it.

What then, does it buy? It buys from the same quality-oriented firms, large and small, that are relied upon by the private practitioner.

In addition, Defense requires potential contractors to submit samples of their products before the contract is awarded and again there is a substantial rejection rate because of high standards. However, the manufacturer who fails a defense department inspection is still free to continue producing goods for the civilian market.

The new commissioner of the Food and Drug Administration, James L. Goddard, M.D., has several times exploded this myth, also. In an interview conducted by the *Pharmacist's Management Journal*, this past March, he had the following to say:

"I think it's going to require very careful study before anyone could assume that there is such a thing as

generic equivalency on a broad scale in our drug field today. There will have to be better methods of determination of equivalency than we now have, and more attention to the entire problem. It's not a simple issue. We appreciate this."

In the same testimony given before a Senate subcommittee the following examples of Department of Defense experiences with drugs of supposed generic equivalency were presented. It is important to note that these are some of the "bargains" that are frequently mentioned as being "saviors of the consumer's pocketbook."

- On September 15, 1961, the commanding officer of the U. S. Naval Hospital, San Diego, California, reported that his neurology department had received "many valid complaints of toxicity and lack of potency regarding this drug — Diphenylhydantoin Sodium Capsules, made by company A, and sold by company B. Complaints included increase in seizure (the drug is used primarily for the control of epilepsy), dizziness and drowsiness. The patients were mostly children.

- March 20, 1962, the Fitzsimmons General Hospital, Denver, Colo., reported that "recently several patients at Fitzsimmons General Hospital who have convulsive disorders have had onset of break-through of their seizures, and each individual stated that they wondered whether the medication was not involved, since they had been seizure-free for several years with Parke-Davis Dilantin capsules with the red band, but recently had obtained medication without the red band. Medication was given of Parke-Davis Dilantin and no seizures have recurred." The report went on to say, "It is recommended that standardized Parke-Davis Dilantin be obtained in order to eliminate the disorders." The generic product had been supplied by Company B and Company C.

- August 7, 1963, the U. S. Naval Hospital, Oakland, California report-

ed that Diphenylhydantoin Sodium Capsules produced by Company D caused "the controlled seizure patient to unnecessarily become non-controlled, which is both physiologically and psychologically contraindicated; absorption from the gastrointestinal tracts of patients has been spotty when this product is used."

- November 30, 1965, the Naval Hospital at St. Albans, New York reported still another series of unsatisfactory experiences with this drug, again from Company D. The neurologist "has had seven adult patients with increased epileptic seizures. . . . This drug is intended to be an anti-convulsant and is not producing the effect needed," the report added.

Interestingly, the lot of this product had passed tests in the military laboratory; samples sent to the FDA also seemed to be satisfactory.

- June 9, 1966, Dow Air Force Base, Maine, physicians submitted a complaint about a new lot of Diphenylhydantoin from Company D. "Patients on this drug are experiencing seizures more frequently than on previously available products," they said.

One firm supplied an antibiotic used in urinary tract infections (Methamphetamine Mandelate Enteric-Coated Tablets), but the product would NOT disintegrate. Laboratory tests and x-rays showed the tablets would not dissolve, and hence could not release the medication. When the defense department informed the firm, its response was that the patient be told to bite them in half and swallow the pieces.

In 1964, the military submitted a number of versions of supposedly equivalent Tetracycline tablets for clinical testing to determine if the various firms' products actually got into the bloodstream. August 24, 1964, the laboratory reported that tablets supplied by Company E "gave no measurable blood levels in 7 of the 10 (human) subjects" who were given the product.

One additional example. Nitrofur-

antoin is a widely-used agent against infections of the urinary tract. Often, patients with chronic infections require this drug over extended periods of time. Defense department doctors and hospitals use it in substantial quantities, as do their civilian counterparts. A series of complaints came in on a supposedly generic equivalent to Nitrofurantoin supplied by an Italian firm, Zambon, S.P.A., beginning in 1961 and running through April, 1963.

From military hospitals all over the country the word was the same: This Nitrofurantoin is unsatisfactory. From Walter Reed, evidence that it "almost invariably" caused nausea and vomiting. From Sheppard Air Force Base, Texas, reports of severe rash. Other reports came from military institutions in Virginia, California, Texas, Florida, Washington, Massachusetts, South Carolina, Maryland.

From the Naval Hospital at San Diego, there were detailed reports on a 15-year-old female patient whose condition worsened to near death using this product.

Regarding the last case cited, the hospital's commanding officer made a comment of particular import to the point we are examining. He said, "It is felt that this (young dependent child's) life was jeopardized by SUBSTITUTING AN UNKNOWN PRODUCT for one which for several years had controlled her infection exceptionally well. The cost of two hospitalizations, plus the expensive Colymycin (an antibiotic used against severe infections) and the transfusions, made the substitution in her case of Zambon Nitrofurantoin a very expensive maneuver."

I should add that the product that had helped this young girl well in the past, and which helped her recover her health when she was given it again, was a brand of Nitrofurantoin made by a small but highly-reputed firm, Eaton Laboratories.

These examples are why the Department of Defense in the future is

going to require "evidence of effectiveness in human beings," before a company can qualify to supply it with a given drug. It is well that our physicians note this and continue to place their reliance on prescribing drugs they know, personally, will effectively treat the condition for which they are prescribed. — **C. Thomas Flotte, M.D., Editor, Maryland State Medical Journal, 16:7, pp. 33-36, July, 1967. Reprinted with permission.**

The Price of People: Crucial Quantity in Hospital Costs

I

THE cost of hospital care in the United States is the most serious and disturbing aspect in the complex proposition of financing medical services. It is an economic balloon, caught in the updraft winds of mounting wages, higher priced goods and services, costlier buildings, and inflation. It is irrationally penalized under the same laws of economic behavior which exert a much less damaging impact upon industry. And the outlook for stabilization and leveling off is grimly pessimistic. In short, the cost of hospital care seems to have only one place to go — up and away.

Beneath all the learned, scholarly analyses by the health care cost economists and somewhere behind all the charts, graphs, and mountains of statistics lies the astonishingly simple explanation: Hospital services are personal services provided by human beings to other human beings. Where personal service, individual judgment, and human response are required and demanded, the wage compensation factor becomes predominant as an economic aspect of the service. In addition, this factor weighs heavier upon the entire cost equation when wages paid must not only be brought into a focus of equity in the labor market but also brought upward from a substandard level where they have historically reposed.

It is bitter irony that the night club dancer earns more than the medical technologist, that the beer salesman is better paid than the chief of nursing, that the Las Vegas blackjack dealer takes home a bigger wage than the physical therapist.

As difficult and perplexing as the hospital cost problem is, there is substantial reason to believe that Americans have unobtrusively adopted a convenient system of double values under which they are cheerfully willing to pay for life's pleasures and patently reluctant to shell out for life itself.

II

Economists identify hospitals as "labor intensive" organizations. About two-thirds of every dollar received by hospitals goes out in wages and salaries. Unlike business and industry, personal services are required around the clock in a hospital each day of the year. There is a low and abrupt cutoff point in hospitals beyond which automation is virtually useless; industry is finding new machines to replace the man every day.

Two decades ago, a hospital employed a worker and a half for every patient it served. Today, the ratio is three-to-one. There is a parallel in the entire American system of health care: In 1940, there were five health workers for each physician; in 1950, there were seven; and in 1960, there were 11 such individuals for each doctor. Today there are 13 health workers for each physician, and by 1970, there will be a ratio of 17-to-1 by every reliable indicator.

In just two years, from mid-1965 through the first half of 1967, the number of nurses employed in U. S. short term, nongovernmental hospitals rose from 277,000 to 308,000 and all other hospital-employed personnel rose from about 1.5 million workers to 1.77 million. Naturally, the mean annual wage zoomed to \$5,140 from \$4,072, and this was harshly reflected in the mean salary expense per patient day: This went

from about \$27.50 in 1965 to \$37 in 1967.

But during the same two year period, the mean daily census rose only slightly, to 588,000 from 563,000.

Two primary factors have accounted for the sharp upturn in hospital payroll costs in the past 12 months. First came the new federal minimum wage laws and second, concerted action by nurses, both in their association-sponsored "economic security" demands for annual compensation of \$6,500 and in the "strikes" calculated to dramatize these demands. As a direct consequence, hospital salary levels have increased from 20 to 40% nationwide.

III

The costs of all goods and services which Americans must have are moving upward as is disposable personal income, a quaint way by which the economists describe what we have left after the tax bite. This is also true of all medical, hospital, and health care services. From 1950 to 1965, expenditures for all medical care services in the United States rose from about \$13 billion to nearly \$37 billion, an increase of 186%. During the same period, the population rose 26% so a fourth more people were demanding more health care services at a higher price.

In this same decade and a half, the per capita expenditure for all health care services rose from \$85 to \$194, an increase of 128% in per person outlay. But the clincher is this: In the same period, *hospital costs rose 230%*.

Another series of yardsticks by which to measure this upsurge is also noteworthy. In this 15 year period, hospital costs per admission rose from \$127 to \$320. The cost per patient day went from \$16 to \$45. The total expenditure for all medical care costs in 1950 was 4.5% of the gross national product, the net worth of all goods and services created in a year. By 1965, all such costs amounted to

5.8% of the GNP. But during the same period, hospital costs went from 1.35% of the annual GNP to 2.02%.

So while all medical and health care costs rose 29% of its share of the GNP in 15 years, hospital costs rose 50%. This is the price of people.

IV

As if the critical examination of hospital cost increases were not technical enough, there are even more technical reasons underlying these economic phenomena. In comparison with industry, any "labor intensive" organization is particularly vulnerable to the impact of wages.

In the first place, industry is geared to absorb most or all of the effects of wage increases by concomitant increases in productivity. This is not true of hospitals where personal services can be automated only to a limited extent.

Second, the impact of wage increases on hospital costs is much greater than the effect of equal increases on the costs of industry. As a hard economic fact, the same percentage of increase in hourly wage rates in hospitals and comparable dollar-volume industries can and does have double the effect on the hospital over the profit-incentive business, and here's why.

In business and industry, payroll usually constitutes about 26% of overall production costs. In the hospital, it is about 62%. So the two year increase in hospital payroll costs of about 24% multiplied by the total share which the hospital puts into payroll, that's $24 \times .62$, results in an overall increase of 14.88%. On the other hand, an industrial payroll increase of 24% multiplied by the total payroll share, that's $24 \times .26$, results in an overall costs increase of 6.24%.

In the health care field, the costs hit where it hurts.

V

There is another side of the coin which, in all fairness, ought to be flipped over and examined. Hospitals

have generally done a good job of telling their costs story and in keeping prepayment in insurance organizations acutely aware of their plight. Generally, physicians have been much more reluctant to explain the rising costs of medical practice, and the results have, in many cases, been all too clear.

Perhaps the best example of this open information policy by hospitals has been with Blue Cross. Almost without notable lag, Blue Cross dues and benefits have risen to meet the upward movement of hospital costs. Hospital associations hammer their cost story out in committee hearings in legislatures and in the Congress. While sometimes accused of harsh policies with reference to patients' responsibilities for paying the bill, hospitals have been sternly realistic about money problems. On the plus side, it can be said that they have stayed in business, kept the doors open to the ill and injured, and met the demand for upgraded services and the challenge of changing technology in caring for the patient.

With a per patient day cost of nearly \$60 in sight during 1967 and the sky-bound momentum holding steady, the future of hospital costs is a subject for debate and speculation. There is no reason to disbelieve the few experts who say that it will be close to \$100 per patient day 10 years hence. But with all the rational and technical explanations for the valid reasons underlying these phenomena, there must, at some point in time, come a stabilized economic environment for the hospital. The alternative is for it to price itself unwittingly and involuntarily out of the health care picture as a private institution, because there is a bottom to the bucket just as surely as there is a limit to its sky.

The medical profession can and is playing a critically important role in this succession of events, because it must identify its capacity and capability with that of the hospital in rendering the best medical care. Un-

derstanding, candid liaison, frank and open interchange, and practical innovation are among those things which will help all members of the health care team meet this issue effectively. It must be met, too, because a big slice of the future is riding on it, and the alternative of failure is a specter nobody wants to contemplate. — R.B.K. — **Reprinted from *The Journal of the Mississippi State Medical Association*, Volume VIII, August, 1967. Copyright 1967, the Mississippi State Medical Association. Reprinted by permission.**

21st Clinical Convention of the AMA

IT is with great pleasure that I invite you to my home state this fall, to the AMA Clinical Convention at Houston, November 26-29.

I believe you will find the convention's program particularly interesting; it offers refreshing insights into clinical problems that you will find useful in your practice or professional duties.

This meeting is especially designed to help us keep up-to-date on latest medical developments. For the 21st consecutive year, the AMA has assembled an extensive, well-rounded program outlining current knowledge.

You will be impressed, I think, by the outstanding medical teachers who have accepted the invitation of the Harris County Medical Society and the AMA Council on Scientific Assembly to participate in the scientific program. The Harris County Society has done a fine job in bringing together this program.

For you, the Clinical Convention presents opportunities for refreshing your medical knowledge, for renewing associations with fellow physicians, and for catching a breather from your busy schedule. It promises to be a stimulating four days, worthy of your time.

With my colleagues, the physicians of Texas and Harris County, I cordially invite you to Houston, a dynamic, interesting city that you and your family will enjoy.

See you at the Clinical!

Milford O. Rouse, M.D., President
American Medical Association

Editorial Notes...

The Public Health Service has enrolled 19 additional clinical centers in its Coronary Drug Project and has awarded grants totaling \$1,175,062 to the new entries.

There are now 55 organizations participating in this large-scale clinical trial conducted by the National Heart Institute. The project will determine whether drugs that lower blood levels of cholesterol and other fatty substances can improve long-term survival among heart attack victims. The drugs — ethyl chlorphenoxisobutyrate (CPIB), d-thyroxine, estrogens, and nicotinic acid — have been found to lower blood-lipid levels and to be free of serious toxicity. The VA Hospital service, headed by Dr. Ward Laramore of Indianapolis, is one of the 55 centers.

Dr. Anton Schwarz, who as director of Pitman-Moore's virus research, developed the one-shot measles virus vaccine, was recently honored during a trip to South America by being made an Honorary Member of the Pediatrics Congress of Brazilia and an Honorary Member of the Pediatric Society of Brazil. He delivered a lecture to the Pediatric Congress. Dr. Schwarz was awarded two medals — both of the Order of Merit of Medicine, including the Grand Official, the highest rank bestowed. He is now the Director of the Dow Human Health Research and Development Laboratories in Indianapolis.

Polls of the general public and business men demonstrate an overwhelming sentiment in favor of changing five holidays (all non-religious) to Mondays. This would produce five three-day weekends, allow for more recreational use of the holidays, and lessen the work disruption consequent upon mid-week holidays. Traffic studies show that auto fatalities are either less or no worse when a holiday falls on Monday as compared with the mid-week position. The idea has so much popular support the National Chamber of Commerce has organized a campaign for legislation.

The Hospital Ship, S.S. Hope, will sail to Ceylon next March. This will be the seventh medical mission of the ship and the second trip to Asia. Her first trip in 1960-61 was to Indonesia and South Vietnam. This year she is at anchor at Cartagena, Colombia. The Ceylon visit is scheduled for ten months and will provide for medical education programs in medicine and many paramedical specialties. In its seven-year history, Project Hope has trained 3,450 doctors, nurses and paramedical personnel and has touched the lives of more than a million people on three continents.

The National Cancer Institute's search of the plant and animal kingdoms for new sources of anti-cancer drugs has been extended to undersea plant life. A wide variety of algae species will be studied by the Illinois Institute of Technology Research Institute and Tyco Laboratories. Plants of various kinds are continually evaluated since one of the best known cancer drugs, vincristine, was developed from an extract of the periwinkle plant.

The nursing home care program of the Veterans Administration has provided more than 3.7 million patient-days of care for veterans. The VA now has 4,000 nursing care beds available at 62 of its facilities and has signed contracts with 2,270 community nursing homes providing a potential of 161,000 beds. The VA also has provided grants-in-aid to some states to build and operate nursing care facilities for veterans. One-hundred and fifty-two beds in a state-owned facility at Lafayette, Indiana have been approved; 46 beds at the Indianapolis VA Hospital and 69 beds at the Marion, Indiana VA Hospital are devoted to nursing home type of care. To date Indiana has not been given any construction grants.

A new kind of engineering has been proposed. Based on systems analysis, the new system of knowledge would specialize in the improvement of our environment — actually making the world a better place to live in. Dr. John A. Logan, President of Rose Polytechnic Institute, is chairman of the World Health Organization committee on environmental health engineering. He reports that his committee is recommending the use of science and technology, including the humanities, social sciences, mathematics and natural sciences for such purposes. Environmental health has always dealt with diseases such as typhoid and cholera — in addition to this it must be concerned with overcrowding, air and water pollution and blighted areas. It must, in other words, deal with the products of civilization and the machine age.

Cincinnati will be the headquarters of a new arm of the Public Health Service devoted to eliminating the health hazards associated with urban living. Various activities associated with the National Center for Urban and Industrial Health have been scattered and mostly in temporary housing. All except the Arctic Health Research

Laboratory which remains at Fairbanks, Alaska, will eventually be housed in permanent buildings at the University of Cincinnati.

The Variety Children's Hospital of Miami has a new source of income with a very beneficial side-effect. Scrap all-aluminum packaging material is collected by civic organizations with proceeds going to the hospital. A total of 25,850 pounds was garnered this summer. The monthly income is around \$1,000. The National Brewing Company, Kayo Oil Company, Food Fair Stores and the Reynolds Metals Company instituted the program. It started with all-aluminum beer cans and now includes potted meat cans, household foil, pie pans and TV dinner trays. Side-effect — much less litter.

One hears a lot about the horse-and-buggy doctor and how little he knew and how little he had to work with. Could it be that the reason he did so marvelously well with what he had was that, while he was going around behind a slow horse, he had plenty of time to think?

One argument advanced to favor generic drugs is that the armed services obtain all their drugs on bids under the generic names. One argument which favors brand name drugs is that many of the bids on generic drugs are made by brand name manufacturers and are filled with brand name drugs. All drugs obtained by the services are assayed carefully and accepted only when of satisfactory quality. Maybe so — but one of the disadvantages of professional life in the armed services is that, in spite of the above and possibly because of it, there are enough service drugs of shoddy quality to make the use of them less than a satisfactory and pleasant experience.

1959 plans for increasing the supply of U. S. physicians called for an M.D. graduating class of at least 11,000 in 1975. This will require an entering class of at least

12,000 in 1971. The Association of American Medical Colleges forecasts the added enrollment provided by new medical schools which will open before 1971, adds the new places to be provided by expansion of existing schools, and comes up with an estimated 1971 freshman class of 10,950 — 1,050 short of the ideal number. The time required to plan and construct a new medical school is such that no new facilities will be possible by 1971.

Nobody, anymore, eats, drinks, or uses anything without knowing who made it or where it came from. Nevertheless, there are those in Washington who would have everyone, when they need something as important and possibly as vital as a life-saving drug, obtain it at the cheapest price possible and without any information as to its source and reliability.

Cornell Automotive Crash research reports that seat belts are very important in preventing ejection from the car and spare many lives by this function, but that belts alone have not satisfactorily reduced injury within the auto. Recommendations are for complete redesigning of the front seat compartment, an antipenetration steering column, a new integrated safety seat and shoulder harness and more research to increase protective elements of the car structure. ◀

Two primary factors have accounted for the sharp upturn in hospital payroll costs in the past 12 months. First came the new federal minimum wage laws and second, concerted action by nurses, both in their association-sponsored "economic security" demands for annual compensation of \$6,500 and in the "strikes" calculated to dramatize these demands. As a direct consequence, hospital salary levels have increased from 20 to 40% nationwide.

Meet The Journal Staff



Dr. Lall G. Montgomery of Muncie was originally a member of the Editorial Board from 1941 to 1943, and later from 1947 to 1949. He has been one of the Associate Editors of **The Journal** since 1953.

Dr. Montgomery is a native of Canada and was graduated in medicine at the University of Manitoba in 1929, following a one-year internship in the Children's Hospital of Winnipeg and a second one-year internship in the Winnipeg General Hospital. After two years in the study of tuberculosis at Manitoba Sanitarium, he spent three years as a Fellow in Pathology at the Mayo Foundation.

Since then he has been director of the Department of Pathology of Ball Memorial Hospital, Muncie.

He is a Founding Fellow of the College of American Pathologists, delegate to the American Medical Association from the AMA Section on Pathology and Physiology, and president of the American Society of Clinical Pathologists. He is past-chairman of the Board of Registry of Medical Technologists.

Dr. Montgomery is the author of more than 40 articles in medical literature. He is an avid collector of "Alice in Wonderland" and other

works of Lewis Carroll, and of Eskimo artifacts, each collection being one of the foremost of its kind.

He is a licentiate of the Medical Council of Canada, and of the American Board of Pathology, a member of Sigma Xi, the International Academy of Pathology, and the American Public Health Association, and is listed in "Who's Who in the Midwest" and "American Men of Science."

Dr. Montgomery's interest in community affairs is attested by his membership in and past-presidency of the Muncie Chamber of Commerce and by membership in Rotary International, the Indiana State Chamber of Commerce, and by honorary membership in the Muncie Junior Chamber of Commerce.



Dr. David A. Bickel of South Bend was first actively associated with **The Journal** when he was a member of the Editorial Board for three years beginning in 1950. At the end of this service he was chosen as one of the Associate Editors and has enjoyed this post ever since.

Dr. Bickel is a native of Jasper County, Indiana, where he completed his pre-college schooling before entering Indiana University. He was awarded the M.D. degree in 1921 and participated in internship and residency training at the University Hospital, Western Reserve University, Cleveland, Ohio.

He entered the practice of obstetrics and gynecology in South Bend in 1923, and has been a member of the medical staffs of both the Memorial and St. Joseph Hospitals since that time. He is a diplomate of the American Board of Obstetrics and Gynecology.

Dr. Bickel is a Fellow of the American College of Surgeons, a Fellow of the American College of Obstetrics and Gynecology, as well as holding memberships in the Central Association of Obstetricians and Gynecologists and the Indiana Obstetrical and Gynecological Society.

President's Page

Dear Doctor:

It is rather difficult for me to write this page. I realize full well that by the time it is read, I will have been out of office approximately one month. This year has been trying in some respects with the legislature meeting during the early months of the term of office. I have received several letters from physicians. Most of these letters have been in disagreement with the Indiana State Medical Association policy as set by the House of Delegates. This is every member's privilege.



I attempted to answer each and every one of them to the best of my ability, and to offer to each and every member a chance of rebuttal or actually sitting down and talking with him. I think this method has led to a better understanding by the president, and has led those same men to understand a bit better the problems of the president. I am sure many of you would have acted differently under the same circumstances. What I tried to do was the best that I was capable of doing. It has really been an enjoyable year. I wish to thank the members, House of Delegates, the Council,

the Executive Committee and last but not least, the staff of the Indiana State Medical Association for its most wonderful support and co-operation.

New officers are coming to the forefront and some of us who are now at the age of 47, old men of medicine, will be fading away. The new officers are trustworthy men. They are men who will spend many, many hours of their precious time taking care of the problems of organized medicine for you and for me. I would only hope that you would be as co-operative with them as you have been with me. They are men who are devoted to duty or they would not have arrived at this position within our beloved organization.

Many times through the year I have mentioned that we should elect young men to office. By comparison, Dr. Larson is coming into office with a few more years than I, but I would have you know that having known this man well for the past three years, I can assure you that he is young at heart. In the coming year I would ask you to help him, to trust him and to work hard for him. I would ask you to help him, for all who are president need help in solving the many, many problems. I would ask you to trust him because he is most trustworthy. I would ask you to work for him, for if we do not work together, we shall fall divided. If we all work together to make this organization click and represent us, it shall live a long time. If we do not, we shall all suffer defeat alone. Each and every one alone.

Again, I wish to thank organized medicine for privileges and favors it has shown me in the past. I will stand ready and eager when and if in the future there should be a need for my meager services.

Eugene S. Rife M.D.

The Woman's Auxiliary

REPORTS TO ISMA

The Indianapolis News published the following headline from the Indiana State Board of Health, August 30, 1967: "VD CASES SHOW BIGGEST INCREASE IN WEEKLY REPORT." According to Dr. Albert Marshall, the number of G.C. cases in Indiana for the year of 1966 totaled 5,152; for the first six months of 1967 there were 2,384. For the year of 1966, 89 cases of syphilis were reported; for the first six months of 1967, there were 73 cases.



The medical section of the September 1, 1967 issue of *Time* magazine carried an article entitled "VD Detectives." *Time* states that "VD in the U.S. is increasing at a runaway rate, especially in the high school and college age brackets. There are 300,000 new G.C. cases reported annually as against 20,000 for syphilis. The U.S. Public Health Service believes that the true figures, withheld because of embarrassment or ignorance are close to 1,200,000 and 300,000."

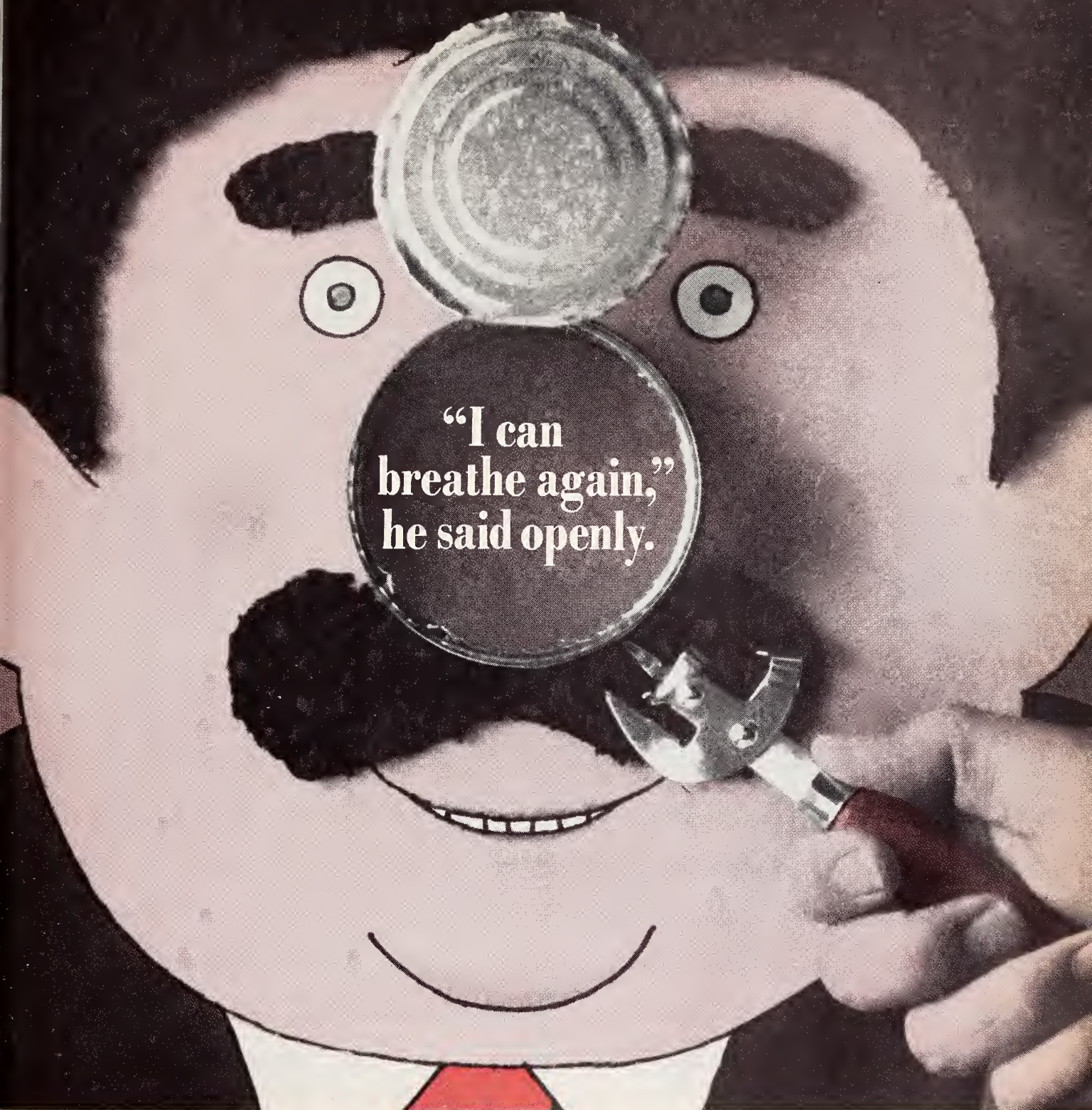
A year ago at the National AMA Convention, the auxiliary state presidents and presidents-elect were introduced to a new package program "Teenage Venereal Disease." This program is in two parts:

A. — is designed to bring to the public attention the alarming increase in teenage VD and to enlist community support in education and control programs directed toward the eradication of VD. This part is to be used for adult representatives of community public and voluntary agencies serving youth and can be presented by an auxiliary member, as there are prepared speeches and films available. However, no member may answer any questions or discuss the etiology, diagnosis or treatment of VD.

B. — is a youth education program on VD to be shown to youth or school groups by request. It is to be presented only by an auxiliary or medical society/auxiliary committee designated for this purpose. For youth education programs, a qualified physician speaker is essential.

Since many of the quoted statistics were unknown to me, I can only assume that there are thousands of others like me. It is my hope that this package program will "catch on" this year, particularly in areas where there is no community agency doing the job.

Roberta P. Deever



in sinusitis, colds, U. R. I.

Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear
breathing on one tablet

It's clear—Dimetapp lets your "stuffed-up" patients breathe easy again. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. Its key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done...in a hurry.

Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. A. H. ROBINS COMPANY, Richmond, Virginia 23220

Dosage: 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

A-H-ROBINS

Preludin[®] phenmetrazine hydrochloride



For complete details,
please see full
Prescribing Information.

helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.

Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A



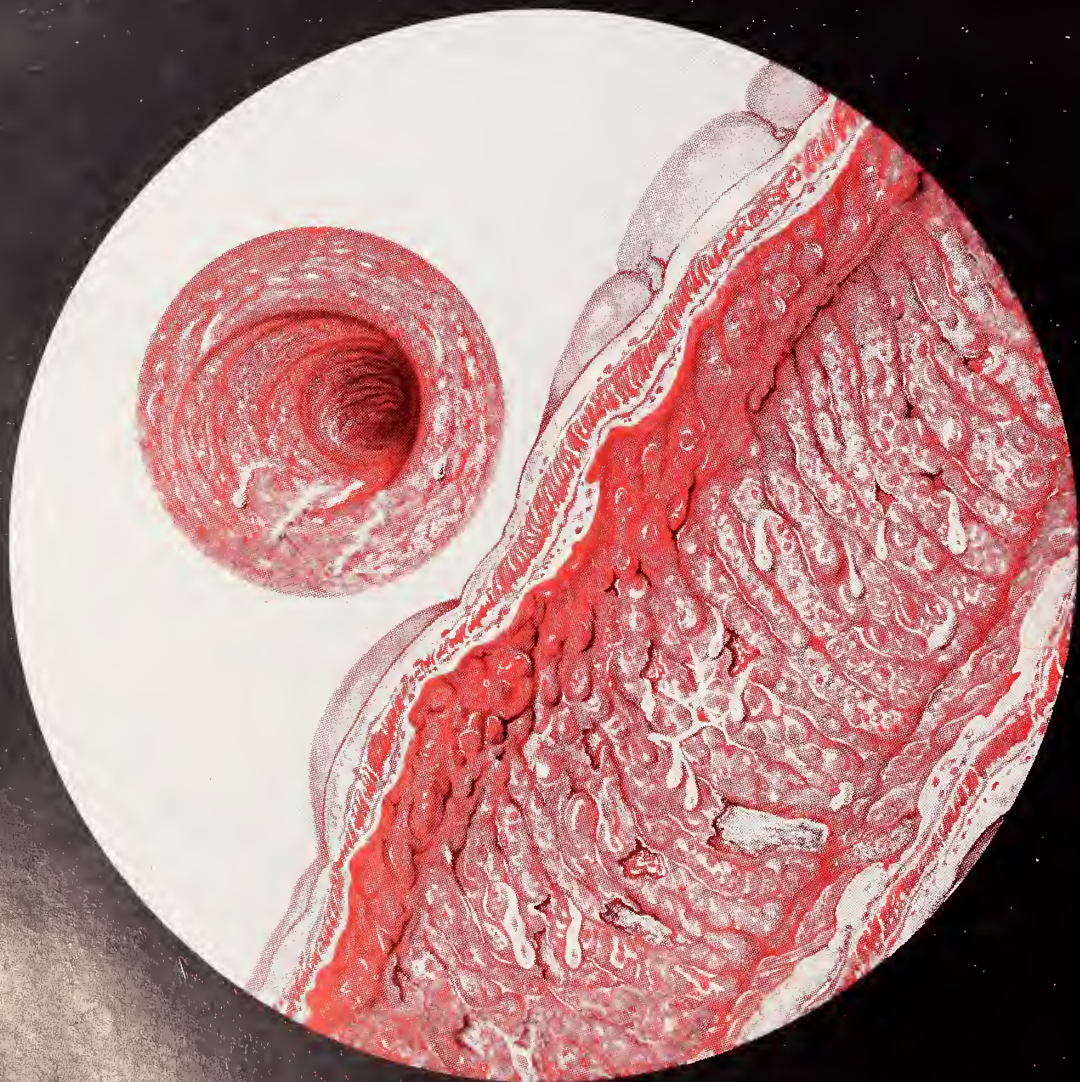
Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

Under license from
Boehringer Ingelheim G.m.b.H.

even in ulcerative colitis...

characterized by:

- diarrhea, cramps, tenesmus
- bloody, mucoid, purulent stools



LOMOTIL[®] tablets/liquid

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride 2.5 mg.

(Warning: May be habit forming)

atropine sulfate 0.025 mg.

controls diarrhea

In six published studies¹⁻⁶ detailed results are given on the use of Lomotil in 111 patients with chronic ulcerative colitis. They show that Lomotil gave satisfactory to "excellent" control of diarrhea in more than two-thirds of these patients. As the disorder advances and destroys bowel musculature, the motility-lowering action of Lomotil, understandably, has less effect.

For correct therapeutic effect Rx correct therapeutic dosage

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are:

Children: Total Daily Dosage

3-6 mo. . . . ½ tsp.*t.i.d. (3 mg.)	🍷 🍷 🍷
6-12 mo. . . ½ tsp.q.i.d. (4 mg.)	🍷 🍷 🍷 🍷
1-2 yr. . . . ½ tsp. 5 times daily (5 mg.)	🍷 🍷 🍷 🍷 🍷
2-5 yr. . . . 1 tsp.t.i.d. (6 mg.)	🍷 🍷 🍷
5-8 yr. . . . 1 tsp.q.i.d. (8 mg.)	🍷 🍷 🍷 🍷
8-12 yr. . . 1 tsp. 5 times daily (10 mg.)	🍷 🍷 🍷 🍷 🍷
Adults: 2 tsp. 5 times daily (20 mg.)	🍷 🍷 🍷 🍷 🍷 🍷
or 2 tablets q.i.d.	🍷 🍷 🍷 🍷

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

Precautions: Lomotil is a federally exempt narcotic preparation of very low addictive potential. Recommended dosages should not be

The successful use of Lomotil in a disorder as exceedingly difficult to treat as moderate ulcerative colitis emphasizes again its unsurpassed antidiarrheal effectiveness in these more common conditions:

- Gastroenteritis
- Acute infections
- Spastic colon
- Drug induced diarrhea
- Functional hypermotility

exceeded, and medication should be kept out of reach of children. Should accidental over-dosage occur signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils and tachycardia. Lomotil should be used with caution in patients with impaired liver function or those taking addicting drugs or barbiturates.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness, insomnia, numbness of the extremities, headache, blurring of vision, swelling of the gums, euphoria, depression and general malaise.

1. Barowsky, H., and Schwartz, S. A.: J.A.M.A. 180:1058-1061 (June 23) 1962. 2. Cayer, D., and Sohmer, M. F.: N. Carolina Med. J. 22:600-604 (Dec.) 1961. 3. Hock, C. W.: J. Med. Ass. Georgia 50:485-488 (Oct.) 1961. 4. Van Derstappen, G., and Vandenbroucke, G.: Med. Klin. 56:962-964 (June 2) 1961. 5. Merlo, M., and Brown, C. H.: Amer. J. Gastroent. 34:625-630 (Dec.) 1960. 6. Weingarten, B.; Weiss, J., and Simon, M.: Amer. J. Gastroent. 35:628-633 (June) 1961.

SEARLE Research in the Service of Medicine

A surrealist illustration of a man's back and shoulder. A large, detailed tree with a thick trunk and many branches grows from the man's back. The tree's canopy is a light blue color, while its trunk and branches are a brownish-tan. The man's skin is a warm, light brown tone. The background is a soft, hazy landscape with some green foliage and a body of water in the distance. The overall style is painterly and evocative.

at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food^{1,3}

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.^{1,2} Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.^{1,3}

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels

attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:

New! Ready-mixed Ilosone Liquid 125! (Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

Ilosone®
Erythromycin Estolate



(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by microorganisms sensitive to its action (especially staphylococci, hemolytic streptococci, and pneumococci). The drug is therefore useful in a high proportion of bacterial diseases encountered in clinical practice and particularly in the treatment of bacterial infections of the upper and lower respiratory tract and soft tissues.

In the treatment of acute bacterial pharyngitis and tonsillitis, this antibiotic has promptly eradicated the bacteria (streptococci) and has produced a parallel prompt clinical improvement. There have been no group A beta-hemolytic streptococci resistant to this preparation. In beta-hemolytic streptococcus infections, treatment should be maintained for ten days to prevent the development of rheumatic fever or glomerulonephritis.

Erythromycin estolate has proved to be very effective in pneumococcus pneumonia and in acute bronchitis with pneumococci on culture. Bronchopneumonia and otitis media in children have responded well to its use.

The antibiotic has been used very successfully in staphylococcus infections. Good therapeutic results have been obtained in soft-tissue infections, abscesses, cellulitis, carbuncles, wound infections, and furunculosis.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents. As is the case with any treatment regimen used in these severe conditions, surgical procedures should be performed when indicated, and large dosages of the antimicrobial agents should be employed. In this fashion, Ilosone has been effective in staphylococcus pneumonia, osteomyelitis, septicemia, empyema, and meningitis.

Multiple 500-mg. doses of the drug have also been useful in gonorrhea and syphilis. Since penicillin is the drug of choice for the treatment of syphilis and gonorrhea, erythromycin estolate should be employed for these infections only in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients known to be hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone. **Contraindications:** Ilosone is contraindicated in patients with a known history of sensitivity to this drug and in those with pre-existing liver disease or dysfunction.

Adverse Reactions: Data obtained from seven years' use of propionyl erythromycin ester and erythromycin estolate (Ilosone) indicate that hepatic dysfunction with or without clinical jaundice may occur during or following courses of therapy with the drug.

Changes in liver function tests in such cases have been indicative of intrahepatic cholestasis. The symptoms appear to be the result of a form of sensitization. The initial symptoms have developed in some cases after a few days of treatment but generally have followed one or two weeks of continuous therapy or several courses of the drug. Symptoms reappear promptly, usually within forty-eight hours, if the drug is readministered to sensitive patients. Eosinophilia was noted in peripheral blood counts. The findings readily subsided without apparent residual effects when treatment was discontinued. Recovery was delayed in one reported instance. The physician indicated in this case that either drug-induced jaundice or viral hepatitis may have been responsible for the findings.

In one clinical study involving ninety-three patients treated with the antibiotic, three cases of jaundice were observed and an additional eleven cases developed some changes in liver function tests. Three of the patients had abnormal liver function tests a second time on readministration of the drug.

Even though it is assumed that not all cases of jaundice have been reported, it seems clear that the number is small compared with the amount of drug that has been used. Reported cases have included persons in whom there had been administered other drugs known to be associated at times with hepatic side-effects and cases in which the presence of viral hepatitis or other disease may have been responsible for the findings. In some of the cases, associated gastro-intestinal symptoms simulated the colic of biliary tract disease. In other instances, clinical symptoms and results of liver function tests resembled findings in extrahepatic obstructive jaundice. It appears that the occurrence of jaundice after administration of Ilosone is infrequent, but further investigations are being made to estimate its incidence more accurately.

In those cases mentioned above in which jaundice appeared to be definitely related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalofluorescent and thymol turbidity tests, elevated serum glutamyl oxalacetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Individual idiosyncrasy seems evident since jaundice has not been reported in other patients taking prolonged courses of the medication. Patients with chronic infection have been given 1 to 2 Gm. of the drug daily for periods of two to six months, and patients with rheumatic fever have taken prophylactic doses of 0.5 Gm. daily for two years without difficulty. In one group of 144 patients who received the drug daily for two years, no jaundice was noted. It was of interest that members of six of these patients' families, who were not taking the drug, had episodes of jaundice during the study period.

Transaminase and serum alkaline phosphatase levels were determined in a group of fifty-four adults and children who took 250 mg. of Ilosone daily for an average of sixteen months as a rheumatic fever prophylaxis. The results were compared with those of a similar group of forty-four patients who received penicillin. There were no cases of jaundice in either group. Elevation of SGPT and serum alkaline phosphatase levels during the course of treatment was observed in one patient treated with Ilosone and in two patients treated with penicillin. Seven other patients in the group receiving Ilosone and four others in the penicillin group showed elevations in one of the tests at some time during administration of the drugs.

Very satisfactory therapeutic results, without toxicity, were reported in 102 pediatric patients who received short-term (ten day) courses of Ilosone in the treatment of streptococcus infections. Results of liver function tests in these patients were comparable to those in a similar control group who had received penicillin.

Gastro-intestinal disturbances not associated with hepatic effects are observed in a small proportion of individuals as a result of a local stimulating effect of the medication on the alimentary tract; however, the normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Although allergic manifestations are uncommon with the use of erythromycin, there have been occasional reports of urticarial skin eruptions, and, on rare occasions, anaphylaxis.

Administration and Dosage: Ilosone is administered orally.

Ilosone Pulvules®, Ilosone Liquid 125, Ilosone, 125, for Oral Suspension, Ilosone Drops, Ilosone Chewable Tablets.

For infants and for children under twenty-five pounds of body weight, the usual dosage is 5 mg. per pound every six hours; for children twenty-five to fifty pounds, 125 mg. every six hours (Tablets Ilosone Chewable should be chewed or crushed and swallowed with water.)

For adults and for children over fifty pounds, the usual dosage of Ilosone is 250 mg. every six hours.

For severe infections, these dosages may be doubled.

When larger doses are indicated, parenteral erythromycin therapy should be considered.

In the treatment of syphilis, the recommended total dosage is 20 to 30 Gm. given in divided doses for a period of ten to fifteen days. Close follow-up of the patient is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examinations of spinal fluid are recommended as part of the follow-up therapy.

For gonorrhea, 500 mg. four times a day for four days are recommended. In the treatment of gonorrhea, patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics, and monthly serologic tests should be made for a period of three months.

How Supplied: Pulvules Ilosone, Capsules, N.F., 125 and 250 mg (equivalent to base), in bottles of 24 and 100.

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60-cc. and pint-size packages.

Ilosone, 125, for Oral Suspension, N.F., 125 mg. (equivalent to base) per 5-cc. teaspoonful, in 60 and 150-cc.-size packages.

Ilosone Drops, 5 mg. (equivalent to base) per drop, in 10-cc.-size packages, with dropper calibrated at 25 and 50 mg.

Tablets Ilosone Chewable, N.F., 125 mg. (equivalent to base), in bottles of 50.

References: 1. Griffith, R. S., and Black, H. R.: *Am. J. M. Sc.*, 247:69, 1964.
2. Griffith, R. S., and Black, H. R.: *Antibiotics & Chemother.*, 12:398, 1962.
3. Hirsch, H. A., Pryles, C. V., and Finland, M.: *Am. J. M. Sc.*, 239:198, 1960.

Additional information available to physicians upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.

Lilly

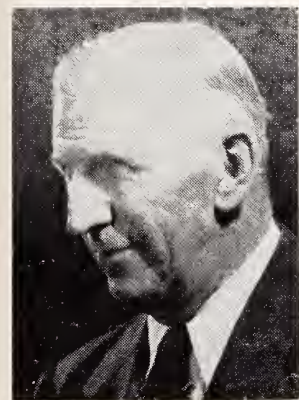
The Passing of the Doctor

GEORGE S. BOND, M.D.
Indianapolis

IT has been my privilege to observe first hand the trends that have taken place in the practice of medicine since the beginning of the century. Some of these have been very good. First, the extension of our knowledge about the various diseases that affect mankind is very impressive.

Many new diseases have been discovered and are considered commonplace today that were not even heard of in the period of which I speak. Because our field of knowledge in this regard has expanded to this extent,

we are now able to give names and definitions to many conditions which were mysteries in the past. As an example, in my own field, we



were aware that the coronary arteries were involved to produce the picture of angina pectoris but the clinical condition now known as coronary occlusion was not even heard of until Herrick described it in 1912.

Secondly, the mechanical, chemical and electrical methods used in the field of diagnosis have been so improved that now we are able to determine definitely just what are the actual anatomical conditions underlying various symptom complexes. The simple methods used in physical diagnosis have improved only a little and these have been largely discard-

ed in favor of the mechanical means. Thirdly, the drugs which we have at our command and other forms of treatment have advanced so far that we now have the means for combating almost every individual symptom and condition. In contrast, drug treatment in the past was confined to a few simple remedies, and one could expect very little benefit from these in many conditions.

An "Extinct" Species

On the other hand, one phase of the practice of medicine has deteriorated and for this, probably, we will be very sorry in the future. This is the disappearance of the family doctor as he was known in earlier days. He is now practically extinct except in some small communities.

In 1958 there were 102,000 general practitioners in the United States while in 1964, they had dwindled to 67,000. In 1950, of the medical school graduates, 50% chose general practice as compared to 18% in 1964.

I am not speaking of the doctor as he was in the post-Civil War days, of whom it might have been said that his personality was his main asset. Many of these doctors were only slightly trained in the meager knowledge of medicine at that time. They had no formal education in medicine and acquired their knowledge by reading, help from another doctor and experience. However, this training gave them all one asset which was very important. Namely — the skill to understand people and their problems.

The doctors to whom I do refer are the ones at the beginning of this century. They were very well educated by a four-year course in medicine,

followed by an internship year in some of the finest medical schools and hospitals. The students of this era were taught by doctors of outstanding ability such as Osler, Thayer, Christian, Herrick and many others who covered the field of medicine but also brought to the classroom long-standing experience in the actual practice of medicine.

These students absorbed a good deal of this knowledge which created in them certain ideals and attributes which they carried out in practice. Also when they settled in a community, they were influenced by the ethics and methods of this older generation of doctors. I appreciate that all doctors then did not conform to this picture but enough did to create the image of the doctor of that time.

Love, Dignity, Respect

What were these attributes that characterized the better doctors of that era?

First, a feeling of personal devotion to his patients who were his friends. He was willing to accept and carry out any extreme demands of time and trouble that the situation might compel. Look at the famous painting "The Doctor" where a doctor is seated in front of two chairs upon which lies a very sick child. Anxiety shows in his face and this is reflected in those of the parents in the background. The light in the window shows the night is over and dawn is approaching. Could you imagine this doctor arising from his chair and saying to the parents "Well I think I will go home and get some sleep. Call me in the morning and tell me how the child is getting along."

Secondly, the doctor then had a feeling of obligation to his families and was at their call at any time. Many a doctor remained at home from a much-needed vacation simply because a member of one of his families came down with some serious ailment which he was not willing to turn over to somebody else. These attributes in turn were reflected on the

doctor himself. Many of the people in the community simply worshipped him and he was set aside in a position of dignity among his fellows as a tribute to his efforts. In addition, it was a psychological asset to the members of a family to realize that they had someone to call in during a crisis whose knowledge and personality could stand in their stead in the worries and stresses of the calamity.

Thirdly, he was a man people could go to for their minor ailments such as a mashed thumb, a broken bone, stomach ache, etc., and who was able to determine the seriousness of this lesion. If it was beyond his own skill, he would refer them to someone who probably had greater knowledge along those lines. Many of their problems were largely emotional and who could advise them better than their doctor who had known every angle of their lives for years? Patients did not have to make their own diagnosis and call in a doctor who fitted what seemed to be that category, but could leave all of their problems up to their family doctor.

Fourthly, the doctor of this era had a feeling of obligation to the community. It was here that he was given the privilege of earning a very good living for himself and family and he owed something to the community itself. Consequently, when he was called upon to do some charitable act or to serve on some committee or project without any recompense, he was very glad to do it in repayment for what he owed. He served willingly, sometimes at his own expense, to benefit the community as a whole. In the present setup of the practice of medicine, practically all of this is lost. I think that we will never see again the doctor such as I have just described to you.

Police a Substitute

Do the people want this kind of family doctor anymore? I can say that hardly a day passes that I am not asked the question "Where can I find a doctor like Dr. So and So used to

be." I am sure the people would like to see the family doctor come to life again. I think the public is at a loss to know just what to do, since they have no one to depend upon. This dilemma has raised an interesting side light on the situation. In case of sudden illness, whom do the people call? The Police Department which makes at least a dozen runs a day for purely medical purposes. There seems to be two reasons for this — the patient gets immediate service, and if he has to go to a hospital, there is no question about him getting in at once.

What are the causes of this change in concept of medicine? There are probably several. The most frequently given is the tremendous volume of the knowledge necessary in medicine today. It is said to be more than one individual can hold in memory and it is developing so rapidly that a single man probably could not keep up with it in all its phases. This is only partially true, however, because as one can see, many of the young men who are out in general practice today have an astonishing knowledge of the many ramifications of medicine and diagnosis that have developed in the last few years. Thus an individual can compass the large bulk of what is necessary to know medicine as it is today. Then, there is always the secondary recourse. A man can always send the patient to a hospital in some neighboring community where there are facilities for a more complete diagnosis. Therefore this is not altogether an excuse for a doctor not practicing as it was done in bygone years.

Secondly, one could cite the scarcity of doctors in the field today. This keeps the practicing ones so busy that they do not have time to go into the details and take the other measures necessary to be a complete family doctor. This, however, is not going to be remedied at any time in the near future and consequently cannot help in any way to solve the problem.

There is a third reason which has

not been mentioned very often in articles written on this subject which I think is the primary cause and should not be overlooked. This is the fact that the modern medical schools all over the United States are not turning out practicing doctors but students educated as medical scientists. These men are not particularly adapted to the general practice of medicine.

Why are medical scientists rather than doctors developed in the medical schools? To answer this question one has to go back to the beginning of the century again. Fortunately I have been able to observe the development of this situation from its beginning. At that time medical education was very unsettled. There were many medical schools of excellent quality where the teaching was well done and usually under supervision of either private or state universities. On the other hand, institutions sprang up over the country, largely on a commercial basis, where students were being taught with a very inadequate facility for clinical work and laboratory instruction.

The Flexner Report

In February of 1909, the Carnegie Foundation for the Advancement of Teaching decided to make a complete survey of professional education in the United States. For this purpose, Mr. Abram Flexner was appointed to take a two-year period to visit all the medical schools and make a survey as to the facilities and the teaching ability of these various institutions.

In the spring of 1910 he made a full report to the committee of this survey including detailed findings, both good and bad, in all the medical schools. In a summary he suggested changes which could be made that would greatly improve medical education. While many problems were discussed, one which interests us most at this time was a statement as follows: "In the best of the medical schools the first two years were taught by full-time professors who devoted their hours to research and teaching.

In the clinical years all the teaching was done by men who were also in the practice of medicine and had less time for research work." He felt that if schools could be converted to a full-time basis that teaching would be better and the men not having to think about private practice could devote all of their extra time to research work. After a general discussion of this problem by the council, Mr. Flexner was asked if they tried out the method on a single school, which one would he recommend for the attempt? Without hesitation he said he thought Johns Hopkins would be the primary place for trial because it had already established itself as a pioneer in the furthering of the advancement of medical education.

Full-time teaching in the clinical years was not a new idea in Johns Hopkins. Dr. Mall, professor of anatomy, had advocated this even when he was in Chicago and many times had spoken in favor of it after he came to Baltimore. Dr. Howell, professor of physiology, had also advocated the clinical years being made a full-time proposition. Dr. Welch himself seemed to be in favor of the idea. Thus it had been discussed a great many times in the university before the matter came up through the Flexner report. Mr. Flexner came to Baltimore and spent three weeks going over the entire matter with the staff at the Johns Hopkins Medical School after which he made the following report to the Council of Education recommending the following changes — that one million dollars be set aside to be utilized to carry out the following:

1. That the school should be reduced to 150 students.
2. That \$40,000 should be used to equip the Hunterian Laboratory for research.
3. That the Departments of Medicine, Surgery, Pediatrics, Psychiatry and the Women's Clinic be placed on an all full-time faculty basis.

By the early part of 1911, this pro-

gram was under discussion by the Board of Trustees of the Johns Hopkins Medical School and the University Hospital. There was considerable difference of opinion: the academic faculty was largely for it but the clinical teachers were pretty well aligned against it.

Dr. Osler's Rebuttal

In the spring of 1911 Dr. Osler, who by this time was Sir William Osler and head of the Medical Department of Oxford University, wrote a very critical letter to the board of trustees of the medical school. The following summary of parts of this letter will demonstrate how much Osler was against this proposition as a whole. "Dear President Remson: The subject of whole-time clinical teachers on which I send you this promised note is one of great importance not only to the universities but to the profession and the public at large. It is a big question with two sides. I have tried to see both as I have lived both, and as much perhaps as anyone, can appreciate both. Mr. Flexner's report has many mistakes from which a man who knows the profession only from the outside could not possibly escape. To say, as contrasted with the instructors on the laboratory side, the clinical staff has been on the whole less productive and less devoted is simply not true.

"In Johns Hopkins it is not too much to say that the clinical men have done scientific work of a standard equal to that of the highest of any laboratory man connected with the University. These are the men who have built the reputation of the school. Their work in practical import namely to translate the Science into the Art could never be done by a purely laboratory man. The special advantage claimed for the full-time system is that the professors will be better able to promote research. Some of the most revolutionary researchers in modern medicine have come from private laboratories, and when thoroughly trained, there is no reason

why the very best work should not be done by practitioners.

"The Research Institutes also are destined to play an ever-increasing part. These institutes will afford ample scope for the men who desire to be clinical researchers. The University Hospital is in a very different position. The care and cure of patients and the teaching of young men the art of medicine are functions coordinate with the advancement of knowledge.

"The director of a medical school clinic has the student as well as the hospital to take care of and whether it will be to our advantage to cut off his affiliation with the profession and the public which he has heretofore enjoyed, is the question at issue. In such a clinic the greater part of the work must be done by the juniors. To be safe the chief must always have about him men who know more than he does on certain subjects. The professors position is to train men who can and would do the work necessary for all research of that particular department. And his main gift is in the ability to coordinate the different departments and to suggest the work that is to be carried on by the men in those departments.

"In consequence a great deal of research can be done in the department but the professor does not need to spend all of his time carrying out that work. The director of a teaching clinic is not chiefly an agent for research. He stands for other things of equal importance — in life, in work, in word and in deed he is an exemplar to the young man about him, students and assistants. His work confined to the four walls of a hospital, practicing the cloistered virtues of a clinical monk, how can he train men for a race, the dust and heat of which he knows nothing, (and this is a possibility, cares less.)

"I cannot imagine anything more subversive to the highest ideal of a clinical school than to hand over young men who are to be our practitioners to a group of teachers who

are ex-officio out-of-touch with the conditions under which these young men will live. The clinical man should come into contact with the public whose foibles they should know and whose advisors they should be.

"Those best fitted as teachers in the medical schools, the men with larger outlook, would soon kick over the traces and leave the positions to the quiet student recluses keen at research. They are as little fitted to train medical students for the hurly-burly of life as I would be to direct a laboratory. The danger would be the evolution throughout the country of a set of clinical prigs, the boundary of whose horizon would be the laboratory and whose only human interest was research forgetful of the wider claims on a clinical professor as a trainer of the young, a leader in the multiform activities of the profession, an interpreter of science to his generation and a counselor in public and private of the people in whose interest after all the medical schools exist.

"With full-time clinical professors the ideals of the medical school would change. I fear the broad-open spirit which has characterized the school should narrow as student and teacher chased each other down a fascinating road of research forgetful of those wider interests to which a great hospital and school must administer. It would be wise to divert the ardent souls who wish to be full-time clinical professors from the medical school in which they are not at home to the research institute to which they properly belong and in which they can do their best work."

Cloistered Counselors

Dr. Osler was right in each of his assumptions, and also that this idea when once started would probably spread. This turned out to be the case because most of the medical schools gradually began to follow suit until at the present time, the large part of our universities are now operating on a full-time basis for the

clinical years. In many instances this has also ramified down through the lesser echelons of the teaching staffs so that the bulk of the men who do most of the actual teaching are now on a full-time basis. Most of them have no connection whatsoever with private practice. Their consultation work done in the hospital itself has very little contact with the outside practice of medicine.

I have seen this program develop in our own school from its beginning. When I first came here in 1914, most of the teachers were doctors working in their profession on the outside. Such men as Wishard, Barnhill, Oliver, Page, Burkhardt and others were all men active in very large practices and were conversant with all the problems existing in what might be called family medicine. In teaching students, they acquainted them with many of the problems accompanying the practice of medicine that had to do with the personal or family affairs of patients. Secondly, they instilled in the students, simply by their presence, many of the ideals for which they stood and which usually remained with the student long after he went out into practice.

In the 1930's one began to see the change taking place in the medical school faculty. There was the constant call for "do more research, more investigating, find something new and publish more." This gradually increased as the years went by until finally we saw the beginnings of a full-time faculty in the clinical branches of medicine. This created an entirely new atmosphere around the institution. The men doing the teaching were spending most of their time pointing out to students the newer changes that were going on in medicine, researching problems themselves and reporting these to the students, reading papers primarily about the physiology, anatomy, symptomatology of disease in its new concept and leaving mostly untold the problems of the management of the patient.

No Personal Touch

What has this done to the students of today? Osler was correct. They are graduated from the university, well versed in all the multiplicity of diseases that have risen in recent times — thoroughly conversant with diagnosis and the many chemical and mechanical means which are available for the solving of these problems — little appreciative of the advantages which might be obtained by close association with the patient and the knowledge of his foibles — not too interested in using the simple means at their disposal of physical diagnosis through the hands, eyes and ears, when other means are available.

If this student goes out into the private practice of medicine, what happens to him? First, he is incapable or does not care to develop the ability to understand the social problems of his patients as they tend to develop into disease. He is very apt to treat the symptoms of the disease by medication, overlooking the fact that relief of the patient's mind might cure the condition without any medication whatsoever. If he feels that there is some emotional problem back of this condition, he is very apt to say to the patient, "I'll send you to a psychiatrist and he will tell you what is wrong with you", which is probably the worst thing he could do. The thought of going to the psychiatrist simply stirs up a lot of inherent fears of mental trouble which a patient may have, whereas her whole medical problem may be caused by worrying over a son who is running around with a gang of bad boys.

The young student going out into practice is immediately beset by the problem of diagnosis and he knows only the methods which he has used in the hospital. Consequently, when any patient comes in with anything that is the least obscure, his answer usually is, "Well let's go to the hospital where we can get some laboratory work done and find out the cause of your trouble." Unfortunately this costs a good deal of time and money

for the patient or insurance company.

Many of these problems could be solved simply by taking more time, going over things more carefully with the patient and then the solution would become apparent. Also this situation is one of the big causes for our scarcity of doctors today. The graduate in medicine will not go to any community where he does not have immediate touch with all the laboratory facilities of a clinic or hospital and which he cannot get along without. Consequently, the smaller towns are bare of recent graduates who might serve as general practitioners there.

The usual answer to these questions from the profession seems to be that the solution is in getting more students into the medical schools. One can frankly counter that suggestion by saying that if 500 students entered

each year into each of the medical schools you would not get very many more practitioners of medicine to supply this much needed field. However there would be an enormous volume of additional medical scientists who would go back into the universities, into the research laboratories or into some special branches of medicine.

Under the present set-up, (which will be worse in the future), the individual patient has to make his self-diagnosis in order to decide which type of doctor would be best fitted to handle his condition. The other alternative would have him go to some private or state diagnostic outpatient institute where his problem could be analyzed and a diagnosis made. Then he can be shunted into the proper channel for care and treatment.

In all of this the personal relation-

ship between doctor and patient is lost, and we are well into socialized medicine. Everything would be much better if some form of teaching could be instituted which would train the doctor to go out, accumulate his families again as of yore, treat the minor ailments that came to him and could be handled in the office, send patients to the hospital or to specialists if he finds conditions for which he wants some other help. Then we would again have a group of practitioners of medicine working for the best interests of the patient.

Acknowledgment

I wish to give credit for refreshing my memory as to the conditions which existed in Johns Hopkins at the time that the full-professorship was instituted to: Dr. Chesney, "History of Johns Hopkins Medical School," Volume IV. ◀

1221 N. Delaware St.
Indianapolis 46202

HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

- * 125 In-patient beds —
- * Day Hospital program —
- * Full time attending staff of psychiatrists —
- * Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
- * Qualified staff of psychologists —
- * Social Service department —
- * Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

James L. Hagle
Administrator

Carnation research and development laboratories
announce the first optimum-nutrition infant formula

Optimil



This extended formula, completely compatible with the infant, has demonstrated its advantages over older modified-milk formulas in intensive clinical tests.¹⁻⁴

It provides:

OPTIMUM CONTENTMENT.

New Optimil's marked superiority in achieving satiety—reflected by infants' infrequent crying—is most reassuring to mothers.

OPTIMUM DIGESTIBILITY.

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

OPTIMUM GROWTH.

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Optimil is recommended as regular feeding for optimum growth and development of normal newborns; as an ideal supplement to or replacement for breast milk; as sound nutrition for prematures; and as prophylaxis against both essential fatty acid and nutritional iron deficiency.

Optimil, diluted 1 to 1 with water, provides a standard feeding formula—20 calories per oz. Supplied in new, convenient 16-oz. cans, Optimil is available for your specification at leading drug stores.



The complete Optimil system available to hospitals includes: 5% Glucose Water in presterilized 4-oz. disposable bottles • Optimil 13 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil 20 calories/oz. Prepared Formula in 4-oz. disposable bottles* • Optimil Concentrated Infant Formula in 16-oz. cans • Sterilized disposable nipples • Optimil Gift Pack: six 4-oz. disposable bottles of Optimil 20 calories/oz. Prepared Formula* and one 16-oz. can of Optimil Concentrated Infant Formula.

*prediluted and sterilized

1. Carson, M., and Hart, L.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," Colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine at Cleveland, Ohio, Sept. 8, 1966. Data available on request.

2. Hepner, R.; *ibid.* 3. Nichols, M.; *ibid.* 4. McCann, M.L.; Terey, T., and Wallace, W.; *ibid.*

Watch for further details on Optimil, the first optimum-nutrition infant formula

from a world leader in nutrition—**Carnation®**

CARNATION COMPANY / 5045 WILSHIRE BOULEVARD / LOS ANGELES, CALIFORNIA 90036



Blue Shield and Blue Cross Again Return Most in Benefits

Blue Shield and Blue Cross Plans in 1966 again returned more of their income in the form of benefits than any type of health insurance or prepayment. According to the Health Insurance Review's annual compilations, Blue Cross and other hospitalization organizations returned 93.2% of income in the form of benefits, compared with 76.7% for the remainder of the industry. Blue

Shield Plans returned the second greatest proportion, 88.9%. Almost \$8.271 billion was collected by the health insurance industry in 1966, and \$6.342 billion was returned for claims. Blue Cross and other hospitalization plans collected \$3.206 billion in subscription income and returned almost \$2.988 billion. The breakdown by type of coverage:

	Premiums Earned Less Dividends	Claims Incurred	Benefits Returned
All health insurance except Blue Cross, Blue Shield and other hospital-medical organizations	\$8,270,984,030	\$6,342,206,681	76.7%
Group health insurance except Blue Cross, Blue Shield and other hospital-medical organizations . .	5,563,870,712	4,856,079,225	87.3%
Individual health insurance including non-cancellable	2,707,113,318	1,486,127,456	54.9%
Non-cancellable and guaranteed renewable health insurance	693,096,646	324,139,829	46.8%

	Earned Subscription Income	Expense Payments Made	Benefits Returned
Blue Cross and other hospitalization organizations	\$3,206,166,948	\$2,987,892,032	93.2%
Blue Shield and other medical-surgical organizations	1,726,418,214	1,535,047,236	88.9%

W. C. Huddleston
Communications Division

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each

Tussagesic[®]

timed-release tablet contains:

Triaminic [®]	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide.....	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

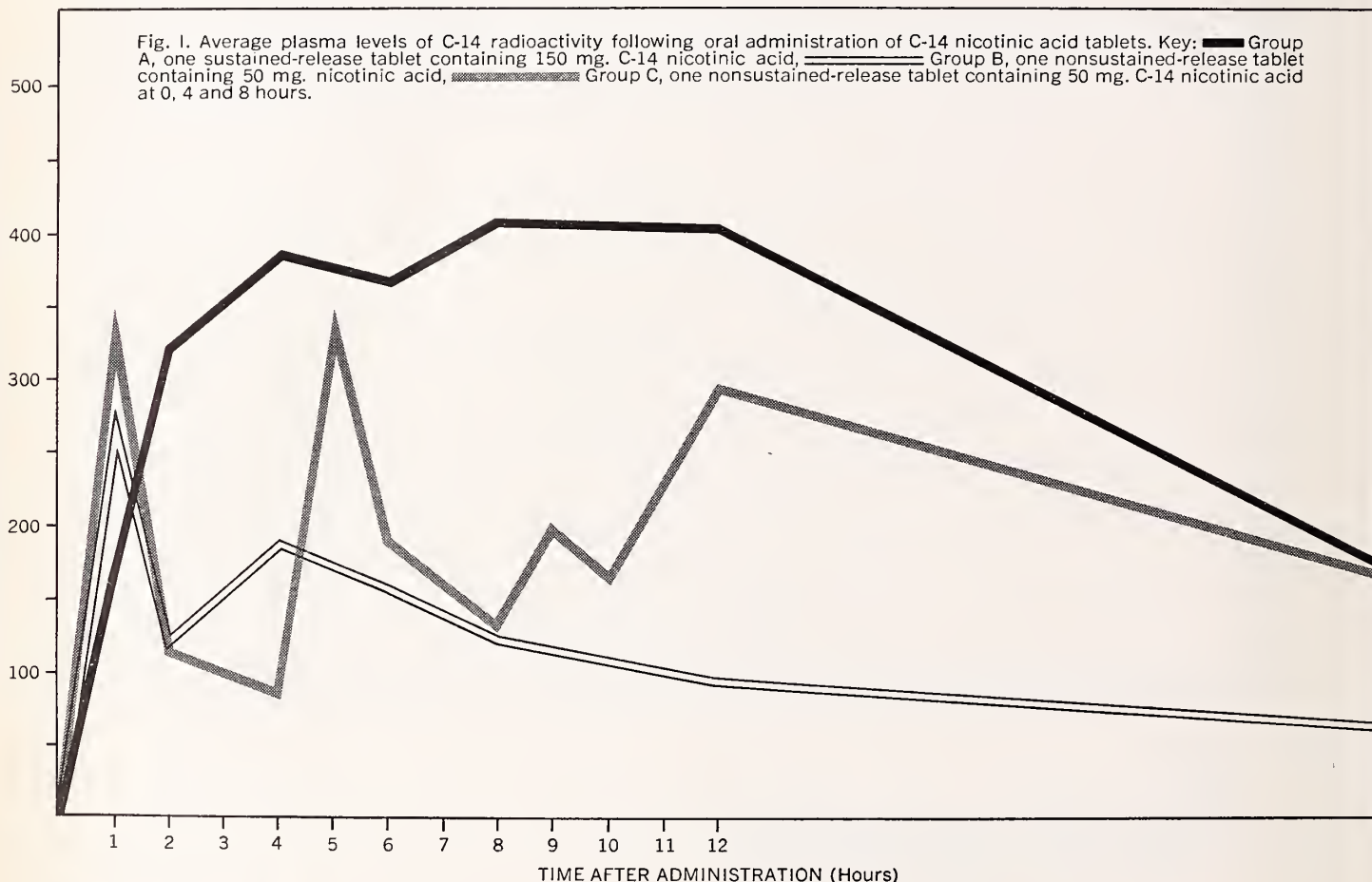
For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey
Representative

Sustained circulatory, respiratory and cerebral stimulation for the

Fig. 1. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: — Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, — Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, — Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

C-14 AS MICROGRAMS NICOTINIC ACID PER LITER OF PLASMA



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

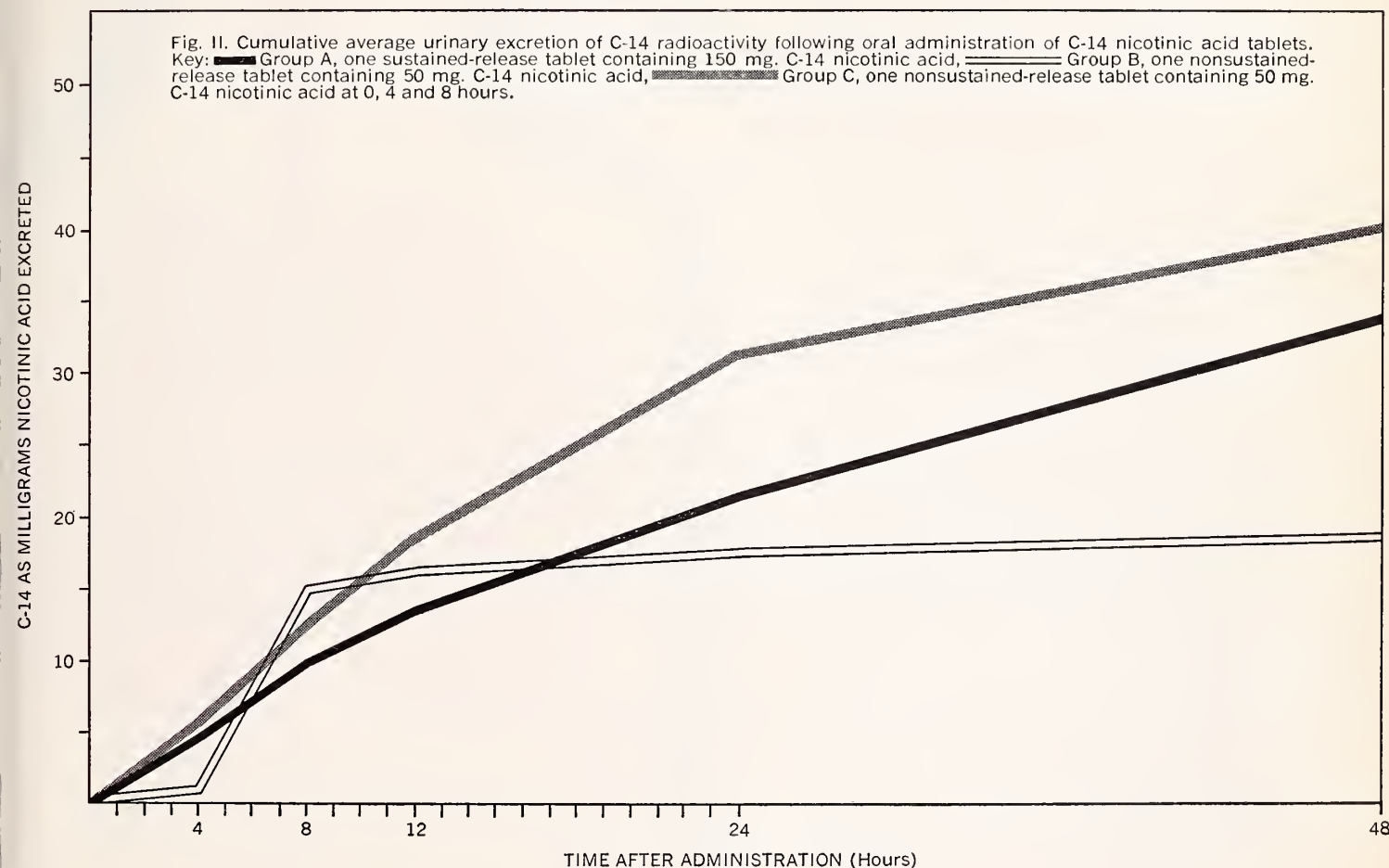
Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylentetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylentetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



"First with the Retro-Steroids"

PHILIPS ROXANE LABORATORIES

Division of Philips Roxane, Inc., Columbus, Ohio

A Subsidiary of Philips Electronics and Pharmaceutical Industries Corp.

Geroniazol[®] TT

nicotinic acid 150 mg., pentylentetrazol 300 mg.

Tempotrol[®] Time Controlled Tablet



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odium
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director



one step
ahead

Times change and classic lobar pneumonia is rare. Your next pneumonia patient may have an atypical clinical picture and perhaps a pathogen in his sputum such as *H. influenzae* or *Mycoplasma pneumoniae* (Eaton Agent), which is believed to be responsible for one out of every five cases of pneumonia. That's why it makes sense to keep one step ahead—and prescribe the true broad-spectrum antimicrobial activity of DECLOMYCIN.

With DECLOMYCIN, you get effective action against both *H. influenzae* and *Mycoplasma pneumoniae*, plus prolonged high levels of antibiotic activity in the blood and the lung tissue. You're one step ahead with...

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE



Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

For common and unusual pneumonias

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth — dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

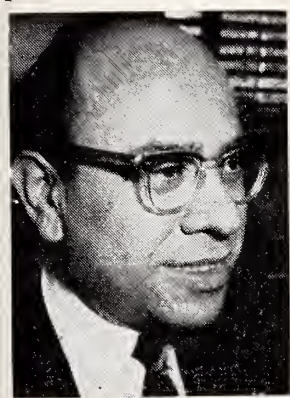
DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York



News from Indiana University School of Medicine

DR. MORRIS GREEN, director of the outpatient clinics at the James Whitcomb Riley Hospital for Children since 1957 and professor of pediatrics in the Indiana University School of Medicine at Indianapolis, has been named chairman of the Department of Pediatrics for the school.



Dr. Green succeeds Dr. Lyman T. Meiks, a member of the department since 1931 and chairman since 1951. Dr. Meiks

will remain on the faculty as professor of pediatrics to devote his time to teaching and patient care.

In making the announcement, Dr. Glenn W. Irwin Jr., medical school dean, pointed out that Dr. Meiks is retiring as department head because of a university ruling that requires relinquishment of administrative duties at age 65.

"The span of service which Dr. Meiks has devoted to the school of

medicine," Dr. Irwin said, "has seen many changes. Yet there is one ingredient for academic excellence that has not changed, the determination of Dr. Meiks to provide the best possible instruction for his students and the best possible care for patients served by the department. His services will be extremely valuable to us for a long time to come."

A native of Shelbyville, Dr. Meiks is a graduate of DePauw University and the Johns Hopkins Medical School. He is listed in "Who's Who in America" and is a member of Phi Beta Kappa and its medical school equivalent, Alpha Omega Alpha. He came to the Indiana University Medical Center immediately after finishing his residency at New Haven Hospital, New Haven, Conn.

One of Dr. Meiks' former students, Dr. Green holds both A.B. and M.D. degrees from Indiana University. He is a member of Phi Beta Kappa, Alpha Omega Alpha, and Sigma Xi, science honorary. He is co-author of a forthcoming volume, "Office Pediatrics," which is expected to become a widely used reference work in the field.

Nationally recognized, Dr. Green was a leader in establishing parent education centers in pediatric hos-

pitals. He organized the annual Indiana Multidisciplinary Child Care Conference and has helped plan and establish multidisciplinary clinics at Riley Hospital.

"We are fortunate to have such a well-qualified successor to Dr. Meiks in this important post," Dean Irwin said, "since under Dr. Meiks' leadership pediatrics has become a major part of the medical center's mission of teaching, research, and patient care, as evidenced by the outstanding and growing programs at the Riley Hospital for Children."

A native of Indianapolis, Dr. Green is a graduate of Shortridge High School. He took his residency at the University of Illinois Research and Educational Hospitals and served as an instructor at the University of Illinois. He was an assistant professor at Yale University School of Medicine for five years before returning to the medical center here. He held the Raymond B. Allen Instructorship Award at the University of Illinois and the Francis Gilman Blake Instructorship Award at Yale University. Especially interested in child development, he is the author of several texts, articles and papers. He was a captain in the Army Medical Corps from 1945 to 1947. ◀

INDIANA MEDICAL BUREAU

816 Hume Mansur Bldg.
634-5804

*A Licensed Employment Agency
Specializing in Medical Personnel*

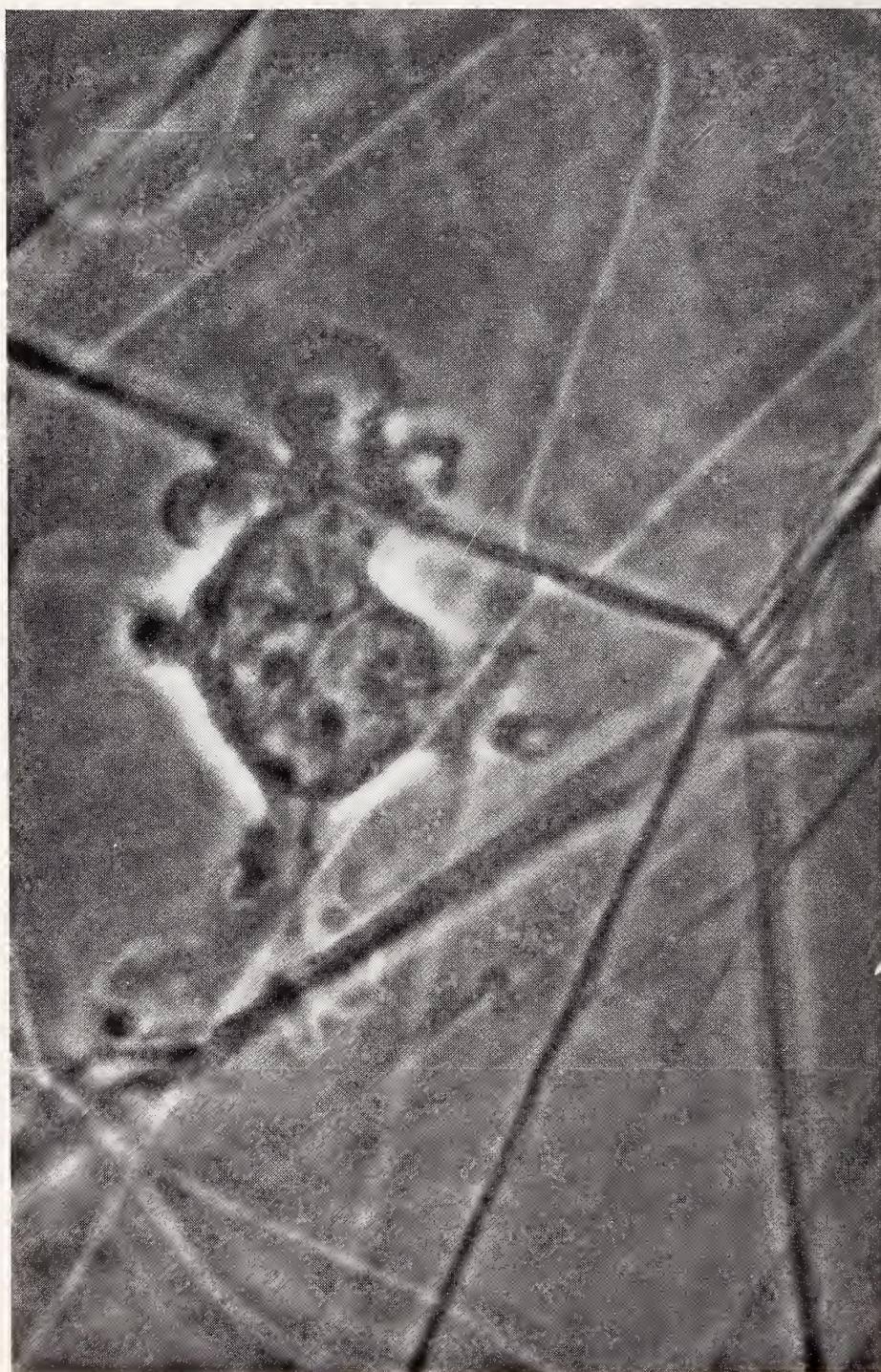
Our 16th Year Of Service

INFLAMMATION: A cellular fight for life

A SYNTEX REPORT based on recently developed hypotheses about topical corticosteroids, including the cellular theories of inflammation by Thomas F. Dougherty, Ph.D., University of Utah.

You are looking at a fibroblast fighting for life. This cell—one of the most common found in connective tissue—has literally been poisoned by cytotoxins released from other cells that have ruptured. Soon, if the abnormal activity of this fibroblast does not cease, it, too, will rupture and die—one more casualty in the inflammatory wave of destruction precipitated by injury.

Until a short time ago no one had ever witnessed such a scene at the cellular level. Now, through advanced cinemicrographic techniques, it is possible to view and photograph the inflammatory process as produced experimentally in living animal tissue. This method permits new insight into the mechanism of inflammation and the role of corticosteroids in therapeutic management. Equally important, these techniques shed new light on factors that may make one corticosteroid more effective than another—factors that can be correlated with other chemical, biologic, and clinical parameters.

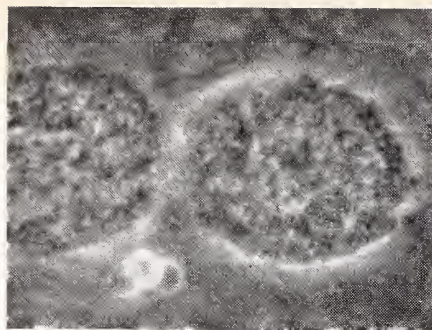


Visual evidence of how corticosteroids influence the inflammatory reaction

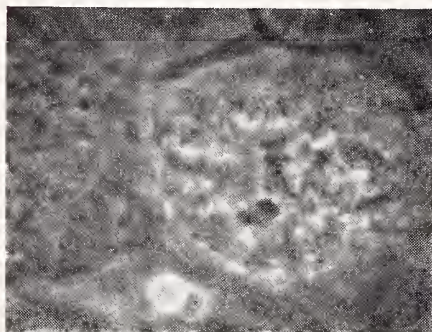
Working with phase-contrast cinematography on living animal tissue, Doctors Thomas F. Dougherty and David Berliner of the University of Utah College of Medicine have actually filmed cellular events that occur during the inflammatory reaction. This remarkable study* and additional work by these investigators, as well as by others, have established a new theoretical biologic basis for the antiinflammatory effect of the corticosteroids. (It must be noted that other theories, such as the lysosome or so-called "suicide bag" theory, have been postulated, although it is quite likely that there are more similarities than differences among the various theoretical models.)

The inflammatory wave of destruction

In this investigation an injurious injection of gelatin is used to set off an inflammatory reaction in living mouse tissue. What follows is a wave of destructive cellular activity that comprises the inflammatory response to injury. Mast cells (which contain heparin, serotonin and histamine) take up water, swell and rupture, releasing their contents, which are toxic outside the mast cell wall. These toxins, in turn, cause disintegration of other cells (such as fibroblasts) and the release of additional toxic material. Capillaries, too, take up water and leak unformed blood elements, causing edema. And polymorphonuclears, lymphocytes and perithelial cells invade the inflamed site. As a result of all these changes, the cellular environment reaches a state of turmoil.



Phase-contrast microscopy showing mast cell before injury.



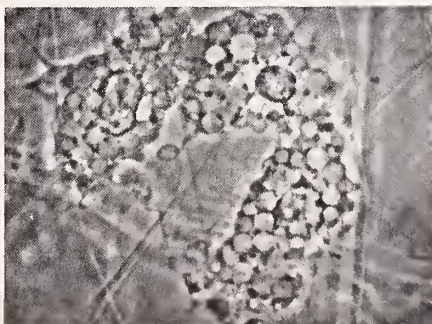
Mast cell (after injury) has broken up and released cytotoxins.

How corticosteroids change the picture

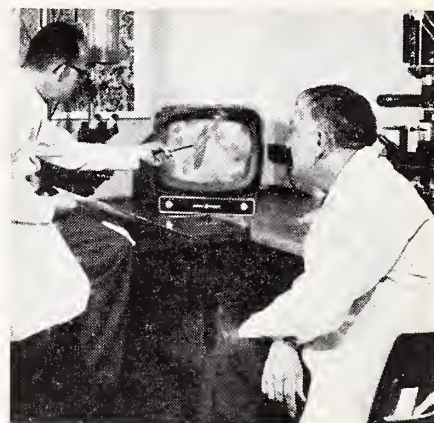
Corticosteroids appear to virtually stop the abnormal cellular activity that constitutes the inflammatory reaction. This permits the body's natural resources to clear up the inflamed area and repair the damaged tissue. This interpretation is supported by the fact that when the injurious gelatin solution is injected simultaneously with a corticosteroid — Synalar (fluocinolone acetonide) — the inflammatory pattern simply does not develop.



Fibroblast in high state of activity, much distorted.



Mast cells showing effects of corticosteroid action: cells are normal in size, shape and activity.

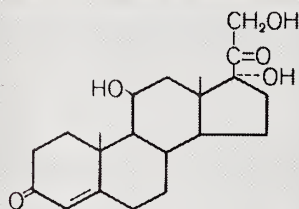


In summarizing his study Doctor Dougherty states: "...we also feel this work may explain why one corticosteroid helps a patient more rapidly and effectively than another. If it does, it is because one corticosteroid is the fastest, most effective inhibitor of the series of inflammatory events at the tissue level."

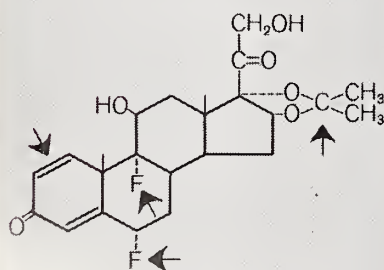
*A New View of Corticosteroid Action in Inflammatory Dermatoses, a film based on this study, is now available from your Syntex representative.

How advances in chemical design have achieved greater steroid potency

The chemical modification of corticosteroid molecules from the advent of hydrocortisone to the development of Synalar (fluocinolone acetonide) is a prime example of how biochemists can "design" to increase therapeutic activity and minimize undesirable side actions. Below, for example, we see the important changes that were made in reference to the hydrocortisone molecule to produce fluocinolone acetonide, one of the most active of all topical corticosteroids. As a result, a 0.01% preparation of Synalar (fluocinolone acetonide) has been reported to do the work of a 1% hydrocortisone product containing 100 times more corticosteroid. And it can often do it more effectively.



Hydrocortisone

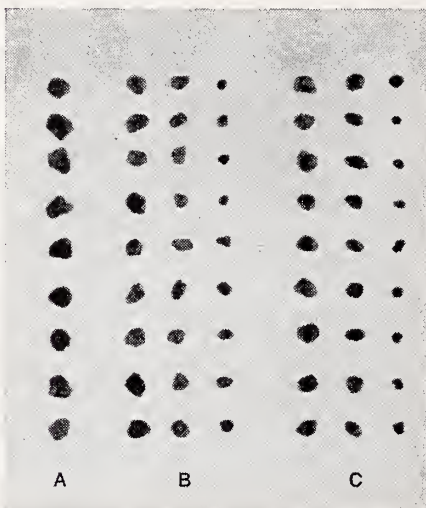


Fluocinolone Acetonide (Synalar)

- a double bond between carbons 1 and 2
- fluorine substitutions at both the 6- α , and the 9- α positions
- the addition of the acetonide at the 16- α , 17- α positions, thus providing one of the most potent topical corticosteroids available.

How bioassay tests are used to "predict" therapeutic potential

Biologic assays are another tool used by researchers to help establish the relative activity of corticosteroids. To date no single method of assaying corticosteroid activity has emerged as the ideal "yardstick" for predicting therapeutic potential. Taken together, however, these methods have proved useful. When such tests are run on various corticosteroids, a definite order of corticosteroid activity becomes evident. Compounds with the highest order of activity may be expected to merit clinical trial to establish their high therapeutic potential. When assayed by these methods, fluocinolone acetonide (Synalar) emerges as one of the most active topical corticosteroids, milligram for milligram, available for clinical application today.



THE THYMUS INVOLUTION ASSAY¹⁻⁴ is run on adrenalectomized rats. The sizes of the glands are measured, and the degree of involution caused by the steroid is determined as an indication of its potency. In the above photo, the comparative involution of thymus glands achieved with hydrocortisone and Synalar (fluocinolone acetonide) is shown. Untreated controls (A) show normal size. Group B — injected with 1, 2 and 4 mg. of hydrocortisone — show progressively smaller thymuses as does Group C — injected with fluocinolone acetonide — but with only 1/500th the dose of hydrocortisone.



THE ANTIGRANULOMA ASSAY¹⁻⁴ also utilizes adrenalectomized rats. Granulomas are induced by subcutaneous implantation of cotton pellets on either side of the thorax. The degree of granuloma inhibition achieved by a steroid reflects its potency. The above photo shows the inhibition of granuloma formation achieved with hydrocortisone and Synalar (fluocinolone acetonide). Untreated controls (A) show large, red granulomas adhering to the pellets. Group B, receiving hydrocortisone and Group C, receiving fluocinolone acetonide, show little, if any, granuloma formation. Fluocinolone acetonide produced the same effect as hydrocortisone with only 1/500th the dose. This assay, as well as the thymus involution assay, measures systemic rather than topical corticosteroid activity. Nevertheless, results by these methods correlate well with other assays and with the milligram potencies of topical steroids in current clinical use.

Worldwide clinical experience confirms the predictable therapeutic potential of Synalar

It is particularly gratifying that the promise of the advanced chemical design and high order of bioassay activity of Synalar (fluocinolone acetonide) has been confirmed by widespread therapeutic application. Indeed, the impressive clinical response rate of Synalar has been documented in no fewer than 232 papers from 22 countries.

PRESCRIBING INFORMATION

For initiation of therapy: Cream 0.025%, 5 and 15 Gm. tubes, 425 Gm. jars; *for emollient effect:* Ointment 0.025%, 15 Gm. tubes; *for maintenance therapy:* Cream 0.01%, 15 and 45 Gm. tubes, 120 Gm. jars; *for intertriginous or hairy sites:* Solution 0.01%, 20 cc. and 60 cc. plastic squeeze bottles; *for infected inflammatory dermatoses:* Neo-Synalar® Cream (0.025% fluocinolone acetonide, neomycin sulfate, equivalent to 0.35% neomycin base), 5 and 15 Gm. tubes.

CONTRAINDICATIONS: Tuberculous, fungal, and most viral lesions of the skin, (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components. **PRECAUTIONS:** Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for pro-

Representative Clinical Results with Synalar*			
Efficacy Documented in over 4,000 Patients			
Condition	Number of Publications	Number of Patients	Significant Improvement†
Contact Dermatitis	27	750	713
Eczematous Dermatitis	21	472	409
Seborrheic Dermatitis	18	442	426
Atopic Dermatitis	24	460	426
Psoriasis	36	1,699	1,510
Neurodermatitis	18	351	324
Total	144	4,174	3,808

*Complete bibliography on request.

†Expressed by the authors as excellent, very good, good, complete remission of inflammation, etc.

longed periods of time. Prolonged use of any antibiotic may result in overgrowth of nonsusceptible organisms; if this occurs, appropriate therapy should be instituted. When severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. **SIDE EFFECTS:** Side effects are not ordinarily encountered with topically applied corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. The neomycin in Neo-Synalar Cream rarely produces allergic reactions.

REFERENCES: 1. Lerner, L. J., Bianchi, A., Turkheimer, A. R., Singer, F. M., and Borman, A.: Anti-inflammatory steroids: potency, duration and modification of activities. *Ann NY Acad Sci* 116:1071 (Aug. 27) 1964. 2. Idem: Comparison of anti-granuloma, thymolytic and glucocorticoid activities of anti-inflammatory steroids. *Proc Soc Exp Biol Med* 116:385 (June) 1964. 3. Ringler, A.: Activities of adrenocorticosteroids in experimental animals and man, in Dorfman, R. I.: *Methods of hormone research*, New York, Academic Press, 1964, vol. III, pp. 234-280. 4. Gubersky, V. R.: To be published.

fluocinolone acetonide — an original steroid from
SYNTEX
LABORATORIES INC., PALO ALTO, CALIF.

For inflammatory
dermatoses...
by any measure
a topical corticosteroid
of choice

Synalar® (fluocinolone acetonide)

Milligram for milligram
one of the most active topical
corticosteroids available

Rapid and predictable
in antiinflammatory and
antipruritic activity

Results often comparable to
those of systemic corticosteroids
with fewer hazards

DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Presumption of Legitimacy Conclusive — In a proceeding by a husband to have an order set aside which required him to support a child born to his wife, a trial court did not err in refusing to admit in evidence results of blood tests which showed that he could not be the child's father, a California intermediate appellate court ruled. It is provided by statute that the issue of a wife cohabiting with her husband, who is not impotent, is conclusively presumed to be legitimate. The provision has repeatedly been held to mean precisely what it says. There was no contention that the husband was impotent and the fact that cohabitation was for only several days made no difference.

Jackson v. Jackson, 56 Cal. Rptr. 240 (Cal., Jan. 23, 1967).

Suit for Patient's Death Following Transfusion States Causes of Action Against Hospital and Blood Bank — In a suit for damages for breach of warranty and negligence against a hospital and a blood bank for the death of a patient from serum hepatitis, allegedly caused by a transfusion of impure blood, a trial court erred in granting the motions of the hospital and the blood bank for summary judgment, a Florida appellate court ruled.

No cause of action for breach of warranty was stated against the hospital. A hospital's furnishing of blood is considered a "service," rather than a "sale." Since there was no "sale"

by the hospital there could be no cause of action against it for breach of warranty.

However, a blood bank's furnishing of blood to a patient for a consideration is regarded as a "sale" to which a warranty can attach. There were statements in earlier cases which indicated that if a factual showing was made that the hepatitis virus is undetectable and unremovable, such showing would be a complete defense to a suit for breach of warranty. Even though blood may be "unavoidably unsafe," this does not relieve a blood bank of the duty of using due care in selecting donors and processing blood. The donor of some of the blood that was given the patient testified that he was asked none of the required questions as to his general health, well being, diseases, and other relevant matters before his blood was taken. Although the donor further stated that he would have answered all of the questions in the negative if they had been asked, a jury could reasonably infer that the blood bank had failed to ask the other donor the questions and find that this was a breach of the blood bank's warranty to take the precautions necessary to minimize the risk of obtaining impure blood. A cause of action for breach of warranty was stated against the blood bank.

It was also alleged that the blood bank was negligent in having delegated the interviewing, screening, and selecting of donors to unqualified, nonmedical employees, and that this

negligence increased the probability of serum hepatitis. Since the blood bank's evidence did not conclusively establish that no question of fact existed as to those allegations, a cause of action for negligence was stated against the blood bank.

It was alleged that since the commercial procurement of blood increases the possibility of hepatitis infected blood, the hospital was negligent in having obtained the blood used from a commercial blood bank. That allegation, standing alone, was not sufficient to state a cause of action against the hospital for negligence. On the other hand, the hospital was not protected from liability merely because the blood bank from which the blood was obtained had met the licensing requirements. The record did not conclusively show that there was no issue of fact as to possible negligence on the hospital's part in selecting the blood bank from which the blood was obtained. The operator of the blood bank was also the hospital pathologist, and a jury could reasonably infer that the hospital had entrusted him with some responsibility in selecting the source of its blood supply. The hospital's purchase of blood from a blood bank which the pathologist knew, or reasonably should have known, to be operating below minimum standards would have constituted a breach of the hospital's duty to use due care in acquiring blood for its patients. A cause of action for negligence was stated

against the hospital.

The hospital and the blood bank were not entitled to summary judgment merely because no evidence was presented in support of the allegations that the patient's death was due to hepatitis and that hepatitis was caused by impure blood. On their motions for summary judgment, the blood bank and the hospital had the burden of showing that no issue existed as to any material fact. They presented no evidence indicating that the patient did not die from hepatitis or that, if he did, it was caused by something other than the transfusion.

Hoder v. Sayet, 196 So.2d 205 (Fla., Jan. 31, 1967; on rehearing, March 10, 1967).

Physician Not Liable in Patient's Suit for Removal of Breast — A patient was not entitled to recover damages in a suit against a physician for his alleged breach of an agreement not to perform a radical mastectomy on her, the New York Court of Appeals ruled.

A biopsy was performed on November 22. The radical mastectomy was performed on November 26. The patient testified that the physician had agreed, at her insistence, to limit the surgical procedure to the removal of the growth itself. The physician testified that the agreement was that he would discuss the pathologist's report with her after the biopsy, and she would have the further surgery if the report showed cancer, and that she agreed to the radical mastectomy after being told that the report did show cancer.

What the patient alleged and tried to prove was that the physician had performed the radical mastectomy without her consent. That would constitute an assault, rather than a breach of contract. The two-year assault statute of limitations had run at the time the patient filed this suit. Further, if there was any agreement, it was that the physician would perform only a biopsy the first time the patient was taken to the operating room. There was no breach of that

agreement.

Pearl v. Lesnick, 278 N.Y.S.2d 237 (N. Y., Jan. 12, 1967).

Insured Entitled to Benefits Under "Continuous Confinement" Clause — An insured, whose heart condition had reduced him to the status of an invalid, was entitled to recover disability benefits under the "continuous confinement" clause of his policy with the insurer, although he did occasionally go outdoors, a Tennessee intermediate appellate court ruled. On the few occasions that the insured does go outdoors, he does so only for the purpose of obtaining the therapeutic value of some mild nonproductive activity recommended by his physician. The insured was substantially confined within doors and was, therefore, entitled to benefits under the "continuous confinement" clause, the court said.

Guarantee Trust Life Insurance Company v. Patterson, 406 S.W.2d 336 (Tenn., June 24, 1966; cert. denied, Sept. 19, 1966).

Ophthalmologist Not Liable for Misdiagnosis of Eye Injury —

A patient was not entitled to recover damages from an ophthalmologist for injuries caused by failure to diagnose correctly the nature of an injury to the patient's eye. In a suit charging the ophthalmologist with negligence, a Georgia trial court entered judgment for the ophthalmologist. On appeal, the appellate court ruled that there was no merit to the patient's contention that several of the trial court's instructions to the jury were improper.

The ophthalmologist had diagnosed the injury as merely an abrasion to the cornea. It later developed that the patient had sustained an intra-ocular penetrating wound. A fragment of steel had penetrated the cornea and lens and lodged in the vitreous at approximately the equator of the eye. The ophthalmologist testified that he found no evidence during his

first examination indicating that the patient had sustained a penetrating wound to his eye.

The appellate court upheld the trial court's instruction to the jury that a physician was not required to obtain perfect, or nearly perfect, results with his treatment and that he was not liable for a lack of success, or for honest mistakes or errors in judgment, unless the evidence showed that he did not exercise the degree of skill and care ordinarily used by the medical profession. The instruction was merely a clarification of the duty owed by a physician to a patient.

There was also no error in the instruction that the law presumes that medical or surgical services were performed in an ordinarily skillful manner, and that the one receiving the services has the burden of showing a want of due care, skill, and diligence. It was merely a standard instruction on the burden of proof.

Surgeon Physically Unable to Practice Specialty Is Totally Disabled —

An insured physician whose practice had been exclusively surgical, but who could no longer engage in such practice because of the adverse effect of necessary sterilization procedures on the dermatitis which had developed on his hands, was entitled to benefits for total disability, even though he was employed in a position which could be filled only by a licensed physician, the U.S. Court of Appeals for the Second Circuit ruled.

In 1933, the physician had been admitted to the American College of Surgeons; at that time, admission required that 70% of an applicant's practice be surgical and that the man be known in the community as a surgeon. Since 1941, the physician's practice had been exclusively surgery. When the dermatitis developed in 1949, the physician consulted a dermatologist. Despite continuous treatment, the dermatitis was not cured, but flared up every time the physician

Continued

engaged in surgical sterilization procedures. In 1952, the physician gave up his practice. Since March, 1953, he has been employed by the Veterans Administration in positions which required a licensed physician but in which he did not diagnose or treat patients.

The policy provided that benefits were payable if the insured was disabled from pursuing his occupation as a physician and surgeon. Although the insured was still a licensed physician and, at least technically, still working as such in his position with the VA, he was totally disabled within the meaning of the policy. "Occupation," as used in the policy, meant the particular work engaged in by the particular insured. This insured's particular work was the field of surgery and he was totally disabled from engaging in such work.

The physician's suit was not barred by the settlement and release he gave the insurer when he first went to work for the VA, because the physician executed the release under a mistake of fact. Nor was the suit barred by the fact that the physician was not regularly under the attendance of a physician. The policy uses the words "necessarily and regularly attended." In this case, "regular" attendance was not required because the physician had made an honest effort to have his condition cured and regular medical attendance would be productive of no beneficial results so far as any return to surgery was concerned.

Dixon v. Pacific Mutual Life Insurance Company, 268 F.2d 812 (C.A. 2, June 19, 1959).

Drug Manufacturer Not Released by Release of Physician — A trial court erred in granting the motion for judgment on the pleadings, by the manufacturer of Kantrex and one of its salesmen, in a patient's suit for damages for injuries which

allegedly resulted from having taken the drug. The claim against them was not released by the release which the patient gave the prescribing physician and the clinic with which he was connected, the Oklahoma Supreme Court ruled.

The release provided that for the consideration of \$3,750, the patient released the physician and the clinic "and all other persons, firms or corporations" from all claims arising out of the incident. A later section of the release provided that in the event other parties were responsible to the patient for damages arising from the incident, the release would operate as a satisfaction of the patient's claim against such other parties to the extent of the pro rata share of the physician and the clinic. There was thus an ambiguity in the provisions of the release as to the parties that the patient intended to release thereby.

Since the patient contracted with only the physician and the clinic, and they paid the entire consideration for the release, the general purport and intent of the contract was to release only them, while also protecting them from enforced contribution under the Contribution Among Joint Tortfeasors Act. To construe the provision as to "all persons, firms or corporations" literally would render the provision as to "pro rata release" meaningless, because if all joint tortfeasors were released, the physician and the clinic would not need protection from the possibility of enforced contribution.

Paclawski v. Bristol Laboratories, Inc., 425 P.2d 452 (Okla., Jan. 24, 1967; rehearing denied, March 28, 1967).

Testimony Based on American Medical Association Directory Properly Admitted — In a suit by an insured to recover benefits under a hospital and medical insurance policy, the admission of a physician's testimony, based on the then current official directory of the American

Medical Association, that the hospital in which the insured had been confined was an approved hospital did not violate the hearsay rule, a Texas intermediate appellate court ruled. There was no material distinction between the directory and items held admissible in other cases, such as railroad timetables, market reports, and quotations in newspapers and trade journals. The physician's testimony, on cross-examination, that even though the hospital was approved as of the date of the directory, something could have subsequently happened so that it was unapproved at the time he was testifying, went to the weight, not the admissibility, of the evidence. The fact that the hospital was listed in the directory, when considered in connection with the insured's testimony about the hospital and the services it furnished, was sufficient to show that the policy requirement of confinement in a hospital recognized by the AMA had been met.

American Bankers Insurance Company v. Fish, 412 S.W.2d 723 (Tex., Feb. 20, 1967).

Beneath all the learned, scholarly analyses by the health care cost economists and somewhere behind all the charts, graphs, and mountains of statistics lies the astonishingly simple explanation: Hospital services are personal services provided by human beings to other human beings. Where personal service, individual judgment, and human response are required and demanded, the wage compensation factor becomes predominant as an economic aspect of the service. In addition, this factor weighs heavier upon the entire cost equation when wages paid must not only be brought into a focus of equity in the labor market but also brought upward from a substandard level where they have historically reposed.

Night Leg Cramps ... Unwelcome Bedfellow In Diabetes,¹ Arthritis,² and Peripheral Vascular Disorders²



now ... specific therapy for night leg cramps

Walker

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose ... helps restore restful sleep.

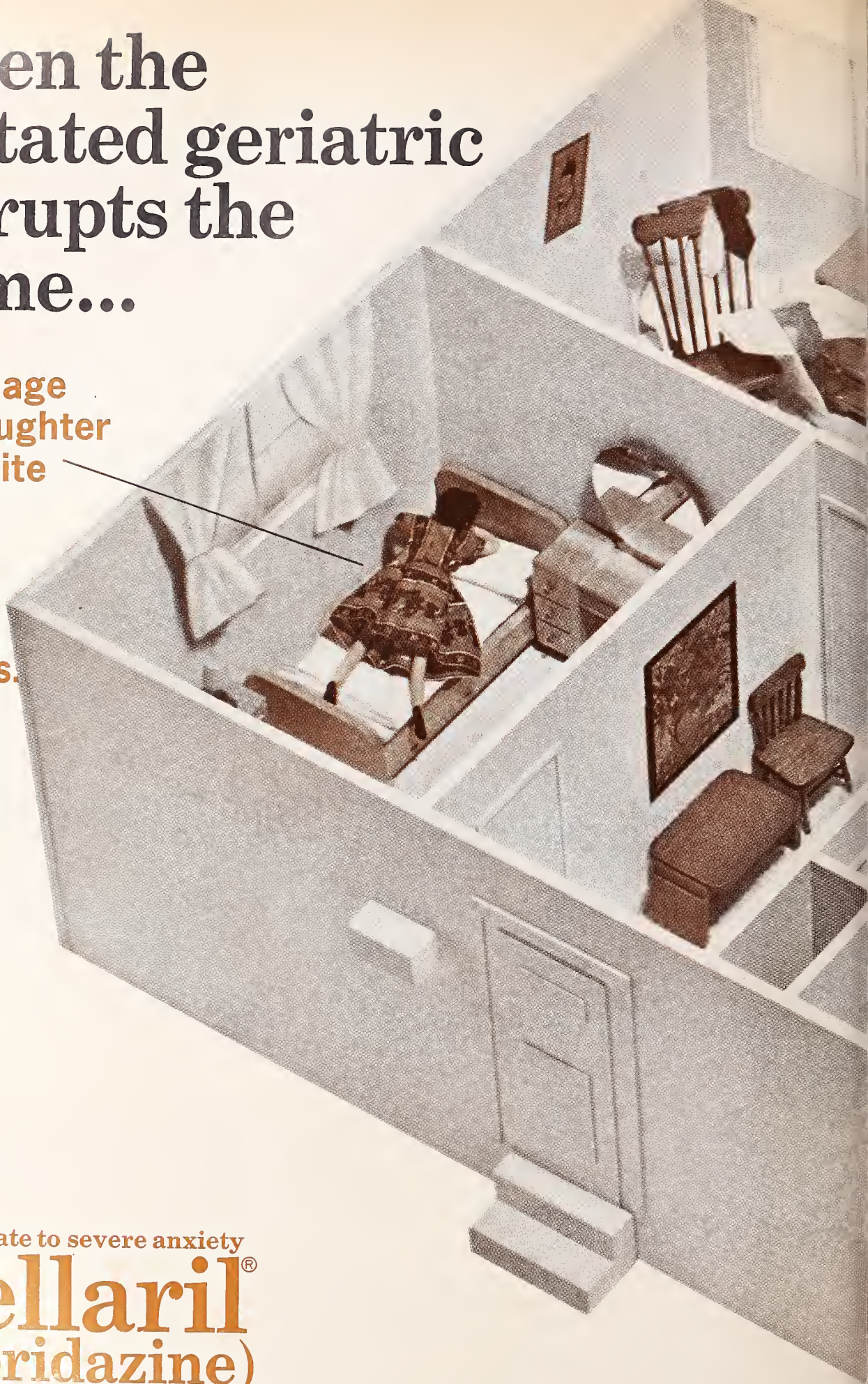


THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL, INC.
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: **Composition:** Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminophylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shumon, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959. 6/67 Q-706A

When the agitated geriatric disrupts the home...

His teen-age
granddaughter
won't invite
friends
home
because
of his
outbursts.



for moderate to severe anxiety

Mellaril[®]
(thioridazine)

25 mg. t.i.d.



**His slovenly room
and habits create
more tension.**

**His disturbances at
the table make every
meal a nightmare.**



**His daughter
can't please him.
There is "just no
living with him."**

See following page for prescribing information

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide..... 195 mg.
Aminophylline..... 130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



WANTED: Physicians Locations

GENERAL PRACTICE

Maurice Paradis, Carol Hospital, Labrador City, Via Sept.-Iles, P. Q., Canada
 Emilio Espindola, 1558 Meyer St., Elgin, Ill. 60120
 Jorge A. Nebe, 3990 Warner Ave., Hyattsville, Md.
 Diego C. Reyes, 8421 New Hampshire, Apt. C, St. Louis, Mo.
 Alfred G. Cruz, Illinois Soldiers and Sailors Home, Quincy, Ill. 62301
 Jose F. Serrano, 399 Bob-O-Link Dr., Lexington, Kentucky 40503
 E. E. Klahr, 8012 E. Rose St., Paramount, Calif. 90723
 Aliye Tugrul, 267 Chamberlin Dr., Hamilton, Ohio 45013—*with Surgery*
 Jaime Gomez, P. O. Box 309, Sedro Woolley, Wash. 98284
 Samson S. Cadiente, 1201 S. Main St., Jacksonville, Ill. 62650—*with Surgery*
 G. C. Lustre, 4471 Granada Blvd., Apt. 101, Warrensville Heights, Ohio
 Floro F. Arive, 3541 Wisconsin Ave., North, Minneapolis, Minn.—*with Surgery*

SPECIALISTS

Martin L. Norton, 217-35 Kingsbury Ave., Flushing, New York 11364—*Anesthesiology*
 Vivente Santelices, 1903 W. Sunnyside, Chicago, Ill. 60640—*Anesthesiology*
 Palmer G. Tibbetts, c/o Veterans Administration Hospital, Wood, Wis. 53193—*Dermatology*
 Kenneth D. Herfkens, 3422 Westgate Rd., Omaha, Neb. 68124—*Internal Medicine*
 William J. Fleming, Box 611, Lucasville, Ohio 45648—*Internal Medicine*
 Anandkumar M. Koyani, 1201 S. Main St., Jacksonville, Ill. 62650—*Internal Medicine*
 Arthur C. Johnson, 1127 Grant, Evanston, Ill. 60201—*Internal Medicine and Gastroenterology*
 Donald C. LaBrecque, 38 Greaney St., Springfield, Mass. 01100—*Internal Medicine with Cardiology*
 Harry A. Spalt, 4 Woodside Dr., South Burlington, Vt.—*Neurology*
 Sadri Alavi, 1246 W. Colt St., Syracuse, New York 13210—*OB-GYN*
 Richard F. Tignor, 419 Baywood St., Vandenburg AFB, Lompoc, Calif. 93437—*Ophthalmology*
 Joseph H. Brandabur, 2736 3rd Ave., Huntington, W. Va. 25702—*Pathology*

James M. Angevian, Tripler Army Hospital, APO San Francisco, Calif. 96438—*Pathology*
 Joseph C. Kopinski, 402 Scotty Dr., San Antonio, Texas 78227—*Pediatrics*
 William J. Tierney, 1744-B 11th St., Langley AFB, Va. 23365—*General Surgery*
 Farrokh Shahbahrami, 2156 Jackson, Memphis, Tenn. 38112—*General and Thoracic Surgery*
 Jose F. Serrano, 1400 Harrodsburg Rd., Lexington, Ky. 40504—*General Surgery*
 Benito C. Liu, 4414 N. Paulina, Chicago, Ill. 60640—*General Surgery*
 Ernesto L. Suarez, 2020 E. 93rd St., Cleveland, Ohio 44106—*General Surgery*
 Charles L. McKeen, 6520 Genoa Rd., Ft. Worth, Texas 76114—*General Surgery*
 L. I. Pena, 627 W. 4th St., Lexington, Ky.—*General Surgery*
 Irineo Z. Gutierrez, V. A. Hospital, Marion, Ind. 46952—*Surgery*
 Sydney A. Garrett, Hale Center, Texas 79041—*Institutional or Student Health Service*

ADDITIONAL LOCATIONS

County	Town
--------	------

DUBOIS—FERDINAND—population 1,500. Modern office building with all major equipment available as well as a large medical practice. No physician in the town. Contact H. G. Erhart, M.D., Huntingburg Clinic, Huntingburg, Indiana or Mr. Wayne Seufert, Ferdinand.

FULTON—KEWANNA—population 700. Located in the lake region of northern Indiana 14 miles from Rochester where a 60-bed hospital is available; 110 miles from Chicago and 92 miles from Indianapolis. Office available. Contact Kenneth Cook, President, Kewanna Progressive Association, Kewanna 46939.

GREENE—BLOOMFIELD—population 2,300. Two physicians in the community—one past 70 years of age. Located 12 miles from a county hospital. Contact Mr. James Sparks, Jr., 14 W. Main St., Bloomfield 47424.

HENDRICKS—PLAINFIELD—population 5,460. Located 18 miles west of Indianapolis on U. S. 40 and 10 miles from Danville where hospitals are located. Population increase for Hendricks County from 1950 to 1960 was 66.3%. Need for general practitioners. Contact Irving Cohen, M.D., 645 E. Main St., the Chamber of Commerce and the Editor of *The Plainfield Messenger*, 307 E. Main St., Plainfield. Telephone 839-6545.

HENRY—NEW CASTLE—population 20,349. Opening for two general practitioners, two internists, one orthopedic physician, one urologist and one ear, nose and throat specialist at the Clinic, 1007 N. 16th St., located adjacent to the Henry County Hospital which has 132 beds and 34 bassinets. Contact George J. Morec, M.D., 1007 N. 16th St., New Castle 47362. Telephone 529-0780.

LA GRANGE—LA GRANGE COUNTY—population 17,400, located in the northern part of Indiana is looking for one or more general practitioners. Contact K. Lehman, M.D., Topeka 46571. Telephone 102.

LAKE—MUNSTER—population 10,325 located in the northwestern part of Indiana close to Chicago. The Hammond Clinic, 7905 Calumet Avenue, Munster has openings in the following fields—general practice, urology, orthopedics, otolaryngology and internal medicine. Contact Donald W. Moore, Director, 7905 Calumet Ave., Munster 46321. Telephone 836-5800.

MONTGOMERY—NEW MARKET—population 700—located seven miles from Crawfordsville where hospital facilities are available. Fully equipped office available. Business Men's Association will give financial assistance in setting up a practice. Contact William H. Davis, M.D., 107 S. Third St., New Market 47965. Telephone 866-0300.

PARKE—ROCKVILLE—opening for a chest physician and a general practitioner on the staff of the Indiana State Hospital for Chest Diseases. Contact Gerald F. Kempf, M.D., Superintendent and Medical Director, Indiana State Hospital for Chest Diseases, Rockville 47872.

VIGO—TERRE HAUTE—population 72,000. Openings for general practitioners, internist, orthopedic physician and ear, nose and throat specialist at the Associated Physicians and Surgeons Clinic, 221 S. Sixth St. Two hospitals in Terre Haute. Contact Robert R. Brown, M.D., 221 S. Sixth St., Terre Haute.

WAYNE-UNION—RICHMOND—population approximately 50,000. Need for several general practitioners, an ophthalmologist, otolaryngologist, psychiatrist and allergist. Contact Darwood B. Hance, M.D., Chairman, New Physicians Committee, Reid Memorial Hospital, Richmond. ◀



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE[®] LP



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis

The Cancer You View

DISCUSSION

From the clinical information alone, oral bleeding, petechiae, and ecchymoses in a previously well patient, one must suspect thrombocytopenia. Prolonged bleeding time and lowered platelet count further confirm this diagnosis. Differentiation between primary or idiopathic thrombocytopenic purpura (ITP) and other types is made rather easily in this case by the white count and examination of the peripheral blood film. The leukocyte count of 30,000 is against a diagnosis of ITP, but does not rule out the unusual case of infectious mononucleosis which also has thrombocytopenia.

The photomicrograph shows the majority of white cells to be of the blast type, possessing relatively large amounts of finely granular, nuclear chromatin and only small amounts of cytoplasm. Nucleoli in these cells are frequent. Occasional more mature cells indicate the type of blast cells present, such as a few mature polymorphonuclear leukocytes and occasional bands and metamyelocytes. Auer rods, needle-like crystals of eosinophilic material in the cytoplasm of the leukemic cells, further identified this as a leukemic process. Auer rods

are not seen in lymphatic leukemia, so this diagnosis may be ruled out. Lowering of the platelet count and the presence of anemia are also characteristic of acute leukemia.

Some problem in diagnosis may be encountered in instances of an aleukemic acute leukemia but here again thrombocytopenia and anemia would probably be present and almost always one can identify leukemic cells, albeit they may be few in number. In most instances, a bone marrow study will resolve the problem. In this case the bone marrow reflected the peripheral blood film as a typical case of acute granulocytic leukemia.

The treatment of acute granulocytic leukemia in a 10-year-old child is the same as in an adult but quite different from the treatment of the more common lymphocytic leukemia of childhood. The regimen includes the use of 6-mercaptopurine (Purinethol) in a dosage of 2.5 mgms. per kilogram body weight per day. Blood transfusions are used to maintain the hemoglobin level at 8-10 grams/100 cc and fresh whole blood is preferred if significant thrombocytopenia is present.

Corticosteroids are essentially in-

effective in acute granulocytic leukemia and should be used only if severe hemorrhagic complications develop. Daily blood counts should be obtained. Serum uric acid levels should be determined initially and again when the white blood count starts to fall in response to the chemotherapy, to detect any hyperuricemia or secondary gout which sometimes occurs as a rapid cellular turnover takes place in a leukemic process. If hyperuricemia occurs, it can be treated with probenecid (Benemid) or the newer Allopurinol. However, if the latter is used, the dosage of 6-mercaptopurine should be reduced to one-third to one-fourth of the usual amount.

The prognosis of this type of acute leukemia is poor. The average survival is about one to two months, and only occasionally will a patient survive for six months. The age of the patient has little to do with the survival in acute granulocytic leukemia. The prognosis is somewhat poorer in patients who present with leukocytosis than in those who present with leukopenia with the same disease. The survival may be prolonged somewhat by treatment, but this is statistically difficult to demonstrate because of the variability of the course of the disease and the toxicity of the chemotherapeutic agents used. ◀

INDIANA UNIVERSITY SCHOOL OF MEDICINE LIBRARY TELETYPE SERVICE

Physicians in over 140 Indiana communities outside of Marion County who do not have direct access to the library may request specific references or bibliographic searches from the Indiana University School of Medicine Library by merely calling their local public libraries and asking that the request be placed by TWX. There is no charge for the teletype call.

Xeroxed copies of the first 20 pages of any one article are gratis. If an article is over 20 pages, a ten cent charge is made for each additional exposure.

For further information write to: Indiana University, School of Medicine Library, Reference Department, 1100 W. Michigan St., Indianapolis, Indiana 46207.

Coming home is wonderful

when you have Blue Cross-Blue Shield

Yes, when you have Blue Cross-Blue Shield, coming home from the hospital is wonderful. That's because the cost of today's quality medical care can be high—and Indiana's most popular health care plan gets you "home free" with its no-worry protection.

If you're a Blue Cross-Blue Shield member, you have a very special kind of security. From the moment you first showed your membership card—recognized and honored throughout the world—you were assured your health care problems would be taken over.

You may not know it but Blue Cross-Blue Shield "takes over" for your employer, too. Your case will give him no claim-filing headaches, no office red tape or paperwork problems. Just as in your own situation, Blue Cross-Blue Shield handles things directly with hospitals and doctors, not involving your employer.

That's why people—all sorts of people—are kind enough to write us: "I don't know what we would have done without Blue Cross-Blue Shield."

Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series of ads being run in key Hoosier newspapers)

when bursitis hits a 280-lb. tackle, hit back with Butazolidin alka



Indications: Osteoarthritis, rheumatoid arthritis, rheumatoid spondylitis, psoriatic arthritis, acute gout, painful shoulder (peritendinitis, capsulitis, bursitis and acute arthritis of that joint), acute superficial thrombophlebitis.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoid those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensive

Adverse Reactions: The most common are nausea, edema and rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic

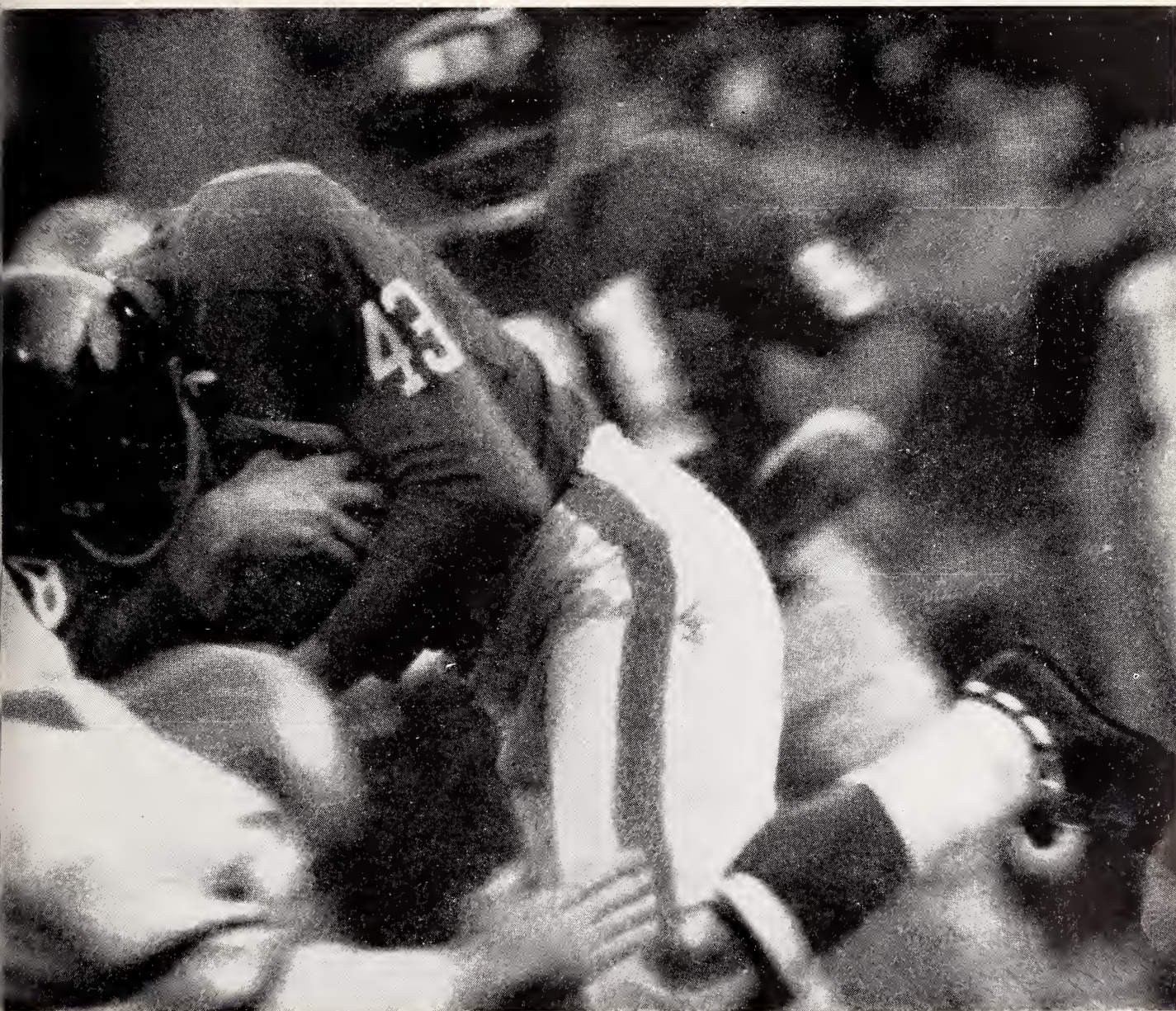
280-lb. tackles — or 108-lb. housewives — Butazolidin alka can hasten recovery from the agonizing pain of shoulder bursitis.

not for every patient. Check carefully the Contraindications, Warning and cautions shown below.

adverse reactions may occur. The most common are nausea, edema and rash. Specially, agranulocytosis has been reported. All adverse reactions are listed below, too.

pay-for-pay or workaday patients — when they come up with shoulder bursitis and your clinical judgment indicates Butazolidin alka — go with it.

watch the comeback.



and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with food to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Severe allergic rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, dizziness, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid aplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

6509-V(B)R2

Butazolidin[®] alka

Capsules

- 100 mg. phenylbutazone
- 100 mg. dried aluminum hydroxide gel
- 150 mg. magnesium trisilicate
- 1.25 mg. homatropine methylbromide

Dosage in painful shoulder: Initial: 3 to 6 capsules daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules daily; response is often achieved with 1 or 2 capsules daily.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, New York



AMA '67 HOUSTON

AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

Plan to attend this year's AMA Clinical Convention in Houston, Texas. Eighteen scientific sessions, four postgraduate courses, breakfast roundtable discussions, color television, and scientific and industrial exhibits will bring you up to date on the latest medical advances. Attend lectures by, and discussions with, our nation's outstanding medical authorities.

Between sessions, enjoy the excellent restaurants, fine shops, visitors' attractions, and mild winter temperatures Houston offers. Mail the enclosed registration and room reservation coupons now, and look forward to an exceptional convention with a holiday plus.

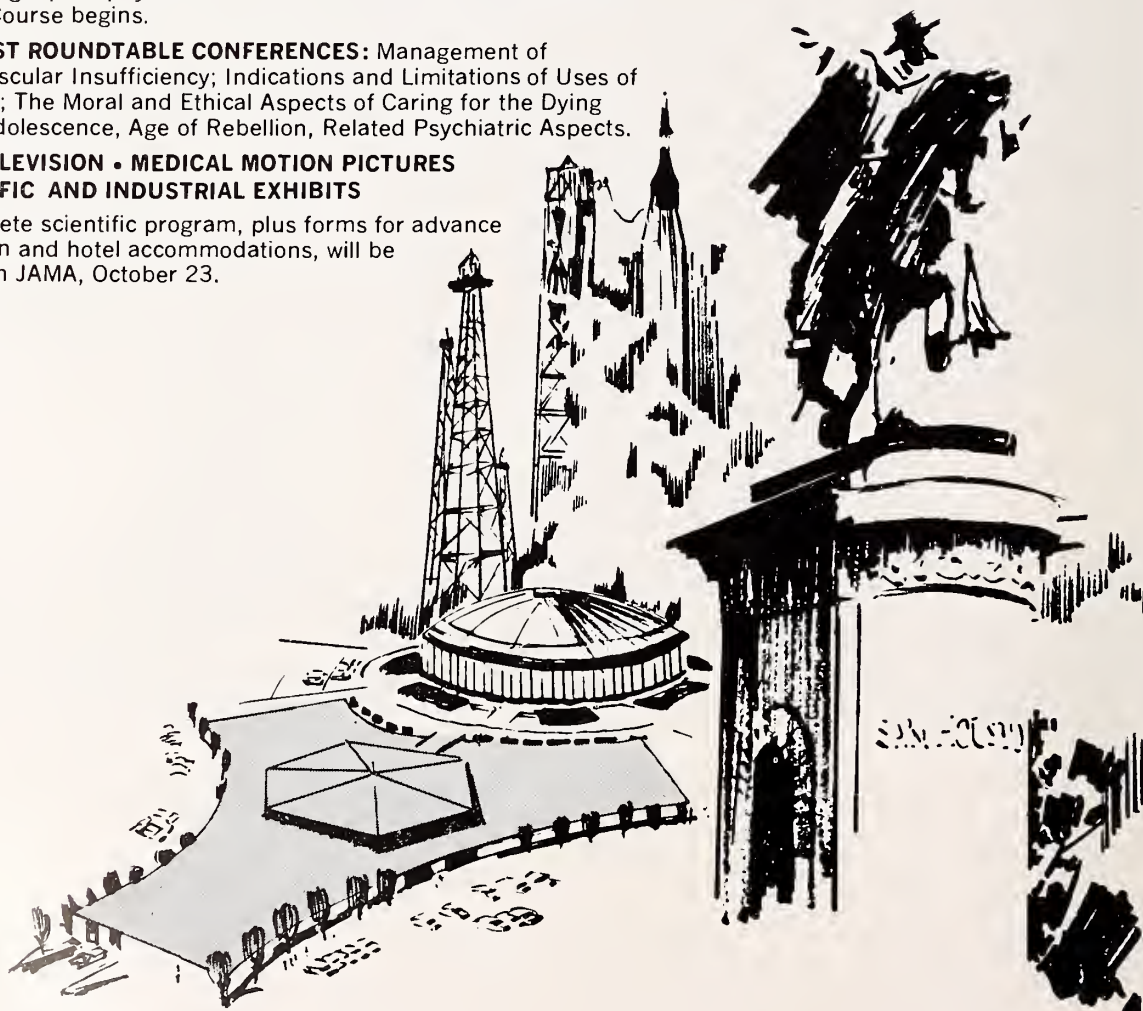
SCIENTIFIC SESSIONS: Cardiovascular Disease; Cardiovascular Surgery; New Cares; Ophthalmology; Geriatrics; Arthritis; Gastroenterology; Cancer; Antibiotics; Endocrinology; General Surgery; Dermatology; Aerospace Medicine; Obstetrics and Gynecology; Psychiatry; Pediatrics; Genitourinary Diseases; and Otolaryngology.

POSTGRADUATE COURSES: Fluid and Electrolyte Balance; Oncology; Cardiovascular Disease; and Obstetrics and Gynecology. Register for these Courses on arrival in Houston at the PG Course Registration booth adjacent to the General Registration area. There is no charge for the Courses, but registration is limited to 200 per Course. The Courses begin promptly at 9 A.M. and 2 P.M. No one will be seated after the Course begins.

BREAKFAST ROUNDTABLE CONFERENCES: Management of Cerebrovascular Insufficiency; Indications and Limitations of Uses of Antibiotics; The Moral and Ethical Aspects of Caring for the Dying Patient; Adolescence, Age of Rebellion, Related Psychiatric Aspects.

**COLOR TELEVISION • MEDICAL MOTION PICTURES
• SCIENTIFIC AND INDUSTRIAL EXHIBITS**

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.



Annual Meeting Dates of Professional Medical and Allied Organizations

AMERICAN MEDICAL ASSOCIATION CLINICAL MEETING

Date November 26-29, 1967
Place Houston, Texas

AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER

Date May 17-18, 1968
Place Stouffer Inn, Indianapolis

INDIANA STATE MEDICAL ASSOCIATION CONVENTION

Date October 14-17, 1968
Place Fort Wayne

NORTHERN INDIANA PSYCHIATRIC SOCIETY

Date Fourth Wednesday of every month,
September through June
Place For location and program, inquire
Beatty Memorial Hospital, Westville

INDIANA ACADEMY OF GENERAL PRACTICE

Date March 26-28, 1968
Place Indianapolis

INDIANA ASSOCIATION OF PATHOLOGISTS, INC.

Date December 2, 1967
Place Indianapolis Motor Speedway
Motel, Indianapolis

INDIANA NEUROPSYCHIATRIC ASSOCIATION

Date Second Wednesday of the month,
October through May, excluding
December
Place The Athenaeum, Indianapolis

INDIANA ACADEMY OF OPHTHAL- MOLOGY AND OTOLARYNGOLOGY

Date May 1-2, 1968
Place Culver Inn, Culver

INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

Date January 10, 1968
Place Stouffer Inn, Indianapolis

INDIANA ROENTGEN SOCIETY

Date May 5, 1968
Place Indianapolis

INDIANA SOCIETY OF ANESTHESIOLOGISTS

Date May 25-26, 1968
Place Marott Hotel, Indianapolis

INDIANA HOSPITAL ASSOCIATION

Date Nov. 1-3, 1967
Place French Lick-Sheraton Hotel,
French Lick

REGENTS MEETING OF THE INDIANA CHAPTER, INTER- NATIONAL COLLEGE OF SURGEONS

Date November 11, 1967
Place Holiday Inn, Bloomington

INDIANA STATE DENTAL ASSOCIATION

Date May 19-20, 1968
Place Murat Theater, Indianapolis

Apologia

A picture of Dr. Gordon Brown, Indianapolis psychiatrist, was mistakenly run in the September Journal in the Pediatric Section.

The vice-chairman of the Pediatric Section is Dr. Wendell Brown, Indianapolis.

We regret any embarrassment or inconvenience caused by this error.



when he just can't sleep
Tuinal

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, $1\frac{1}{2}$, and 3-grain Pulvules**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206

Lilly

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—August, 1967

Disease	August 1967	July 1967	June 1967	August 1966	August 1965
Animal Bites	1091	1245	1626	1038	890
Chickenpox	24	49	117	53	38
Conjunctivitis	47	98	61	158	27
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	22	26	9	44	89
Gonorrhea	428	425	445	474	357
Impetigo	96	116	75	221	244
Infectious Hepatitis	32	23	36	21	43
Infectious Mononucleosis	8	33	34	31	27
Influenza	32	27	50	137	194
Measles (Rubeola-Rubella)	32	55	122	94	123
Meningitis, Meningococcal	0	1	1	7	1
Meningitis, Other	3	7	1	4	5
Mumps	142	261	509	59	70
Pertussis (whooping cough)	36	54	22	23	11
Pneumonia	92	109	204	136	112
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	250	220	277	265	321
Syphilis					
Primary and Secondary	16	13	16	13	3
All Other Syphilis	66	74	231	94	88
Tinea Capitis	0	6	10	12	7
Tuberculosis (Active)	63	70	113	83	114

★

Specialized Service

IN

PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAL PROTECTIVE COMPANY

FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller, Representative

665 East 61st Street Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

BOOK REVIEWS

CECIL-LOEB TEXTBOOK OF MEDICINE

Edited by Beeson and McDermott, 12th edition, W. B. Saunders & Co., Philadelphia, Pa., 1967; 174 pages with numerous figures and illustrations; single volume, \$24.00; two volume, \$30.00.

The extremely competent editors of this standard textbook have adhered to Dr. Loeb's and Dr. Cecil's original program of an updating of their work every four years. In the very nature of things, the change from the 11th to the 12th edition could not be as complete as it was from the 10th to the 11th: after all, that was the break from the older generation to the energetic present-day, younger leadership.

It would be invidious to single out one or two authors from the high nine score contributors for especial praise (or condemnation). I still enjoy thoroughly the three crisp and splendid FOREWORDS as presented by Drs. Atchley, Horsfall and Dubos.

This 12th edition coming just 40 years after the original, illustrates well the WHY of Cecil still being the leader in its chosen field. It is a supererogation to say more!

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

A HAPPIER SEX LIFE

Dr. Sha. Kokken, translated by Robert Y. Totsuaka, Sen Kozuka, Sherbourne Press, Los Angeles, Calif., 1967; 188 pages; illustrated; \$8.50.

This is a translation of a best seller published in Japan in 1960. It is written in non-technical language understandable to the lay person. The author notes that with the collapse of Japanese militarism there was a decline of male dominance in that country with a change in the husband-wife relationship. The purpose of the work is to present information which may aid in happier marital relations through happy sexual relations. This sex manual consists of 188 pages of well written text, well supported by photographic reproductions and pen sketches, with all the veneer removed.

The author, a prominent obstetrician and gynecologist, was formerly chairman of the Japan Red Cross Maternity Hospital, but now operates a private Maternity Clinic. One million copies of this book were sold the first year. Many physicians and most newly married couples are regarded as woefully uninformed regarding sex matters. A manual of this type serves a useful purpose. More knowledge concerning sex for both men and women would certainly prevent many marital disasters.

The book is worth reading for the physician and worth recommending to newly married couples. It is clearly, concisely and tactfully written, and has an adequate index.

DAVID A. BICKEL, M.D.
South Bend

THE PHYSIOLOGICAL BASIS OF MEDICAL PRACTICE

C. H. Best and N. B. Taylor, eighth edition, Williams & Wilkins, Baltimore, Md., 1966; 1793 pages in ten sections and 80 chapters with numerous figures and illustrations.

The very fact of an *eighth* edition in the 30 years elapsed since the first is proof of the unique niche filled by this work. The rather cumbersome wording of the title is evidence that we have

no exact word for *morbid physiology*! Of course, morbid anatomy is pathology; morbid physiology? well, there is the title.

Some half a hundred specialists contribute to the present quite hefty tome. Their combined product is superb—quite up to the minute. However, may I venture a comment? In the praiseworthy endeavor of giving reams of information (part of it rather esoteric), some simple, basic instruction is just left out: the author *assumes* that his audience is familiar with it. As an illustration! A resident asked me the meaning of "chronaxie." The entire discussion on the "Physiological Properties of Nerve" says nothing on this topic. Careful examination of the numerous illustrations did show the word, abbreviated and unelaborated. If the reader already knew the meaning of the concept, he could deduce it from this deeply submerged notation.

So: would future editions retain at least some of the basics even as they add more and more columns of the excitingly new (and of necessity) complicated knowledge that we are acquiring? I trust that the authors will not take this as a carping criticism. In the meantime, I am happy to have the newest edition on my working shelf.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

GREAT IDEAS IN THE HISTORY OF SURGERY

Leo M. Zimmerman, Ilza Beith, 2nd edition, Dover Publications, New York, 1967; 585 pages; 118 illustrations; \$3.00.

This book is not a conventional history of surgery but very interesting biographies of leaders in surgery in the various civilizations and nationalities. Part I is introductory; it is the history of

**WILL BUILD
TO SUIT TENANT**

4700 W. Wash. St.
Corner, Woodrow & Wash. St.
Indianapolis, Ind.

CONVENIENT WESTSIDE LOCATION

Ample Parking
Air Conditioning
Acoustical Ceilings
Indirect Lighting

Carpeting
or
Torginol Floors

CALL 856-5857
For Complete Information

Synirin®

ACETYSALICYLIC ACID (ASPIRIN)..... 5 GR.
 *PENTOBARBITAL (ACID)..... 1/8 GR.
 *Warning: may be habit-forming

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

SYNIRIN is another
pharmaceutical achievement

WM. P. POYTHRESS & CO., INC.
 RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



ABSTRACTS, BOOKS

Continued

the beginnings of surgery in the various centers of civilization. The first chapter deals with early Egyptian surgery. The material for this chapter comes from the oldest scientific document ever discovered, the Edwin Smith Papyrus collection, which is now in the library of the New York Historical Society. Translations of these hieroglyphics give accurate descriptions of primitive surgical treatment which consisted mainly in the care of injuries, lithotomy and opening of abscesses. Most of the procedures were crude and often barbaric.

The second chapter concerns the writings of Hippocrates. In addition to the discussion of general medical subjects, Hippocrates makes many references to surgical treatment. From his writings he appears to have had detailed and accurate anatomical knowledge. Greek culture had its salutary effect on medicine for many centuries.

Surgery like other scientific endeavors advanced slowly until the founding of universities, and postmortem dissection and anatomy came to be considered a part of medical study. Chapter 12 is devoted to the surgeon-anatomists of Italy, Vesalius being the most prominent anatomist.

Part IV is quite appropriately entitled "Surgery Becomes Respectable." Surgery and medicine were not always fused together as essential elements of the healing art. The study of anatomy by postmortem dissection now being accepted, surgery in France, Germany, England and Italy made remarkable advances in the pre-Renaissance era. Primary healing, sutures and dressings for wounds became popular, and the practice took on some rational aspects. Surgery now received the dignity of being taught in universities.

During the Renaissance, Pare and Paracelsus both made worthwhile contributions to the acceptance of surgeons by medical physicians of their times. Many of the surgeons prior to this time were clerics, or had other vocations. With the advances in learning, a surgeon was expected to confine his activities to that sphere of endeavor. Paracelsus admonishes that a surgeon "should not be a hangman, a poet or actor, a priest or run a house of ill fame, and should not make excessive charges." The Germans were widely experienced in the school of military surgery. They made great contributions to our knowledge of both pathology and surgery.

Biographies of many of the pre-Listerian surgeons are presented in detail and are enlightening and interesting reading.

After the 16th century when British surgery began to take the world lead, great names appeared: William Clowes; Peter Lowe; Richard Wiseman; William Chesleden; Percivall Pott; John Hunter; Astley Cooper and Lister. Scotland also produced some outstanding surgeons of this era. A lengthy chapter is properly devoted to the work of Lister.

The last part of the book consists of biographies of modern surgeons. There are chapters on Bassini, Billroth, Kocher, Horsely and Sauerbruch. The work of John B. Murphy, Williams and Potts of Chicago are mentioned in connection with chest surgery. Other American surgeons whose contributions are recognized are: Harkin; Bailey; Wangenstein and Claude Beck. An entire chapter is devoted to Marion Sims and the story of Ephraim McDowell.

The book has a flexible plastic cover and is printed on a good grade of paper. The printing is clear and the illustrations are in keeping with their time.

The authors are: Leo M. Zimmerman, Professor and Chairman, Department of Surgery, Chicago Medical School, and Attending Surgeon, Michael Reese Hospital and Ilza Beith, Professor and

Vice-Chairman, Department of History of Health Sciences, University of California, San Francisco Medical Center. They have produced a scholarly and interesting book that should be in the library of every surgeon. The material is well organized into eleven parts and 47 chapters. There are ample references and a comprehensive index.

DAVID A. BICKEL, M.D.
South Bend

NEUROLOGY

Roy R. Grinker and Adolph L. Sachs, 6th edition, Charles C Thomas, Springfield, Ill., 1967: 1637 pages; 539 figures and numerous tables.

This enormous monograph was a pioneer in its field when first published three decades ago. It still is the popular leader as this latest edition proves.

No less than 20 chapters and a splendid index (as well as several thousand references) give quickly and concisely an answer to any problem facing the clinician. One cannot cavil at the sheer size of the work; the material cannot be compressed into fewer pages.

The type and binding are good; the typographical errors are few and really insignificant. This monograph amply fulfills its intended goal.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various
Literature, Prepared by AMA

USE OF BACTERIAL INTERFERENCE TO
CONTROL A STAPHYLOCOCCAL NURSERY
OUTBREAK: DELIBERATE COLONIZATION OF
ALL INFANTS WITH THE 502A STRAIN OF
STAPHYLOCOCCUS AUREUS

I. J. Light et al. (Children's Hospital Research Foundation, Elland Ave. and Bethesda, Cincinnati)

Amer. J. Dis. Child. 113:291-300, (March), 1967.

A nursery outbreak of a pathogenic strain of *Staphylococcus aureus* 80/81 was recognized in a nonuniversity affiliated community hospital. The outbreak was successfully controlled by purposely colonizing all infants with a previously described coagulase-positive *Staphylococcus* of relatively low pathogenicity (502A). Cultures from the nasal and umbilical sites streaked on media, with and without penicillin, demonstrated that infants colonized with the 502A strain rarely harbor other coagulase-positive staphylococci at the same site. Among the inoculated infants, the low incidence of pustular lesions (less than 50%) and the minor nature of the lesions confirmed the low virulence of the 502A strain. The finding that lesions occurred more frequently when more organisms were inoculated is unexplained. Among the personnel, many of the nasal carriers were transient carriers and lost the pathogenic strain when it disappeared from the infants.


EPIDEMIC ENTEROPATHOGENIC ESCHERICHIA
COLI, NEWFOUNDLAND, 1963: AUTOPSY
STUDY OF 16 CASES

Y.-M. Rho and J. E. Josephson, (St. John's General Hospital, Forest Rd., St. John's, Newfoundland)

Canad. Med. Assoc. J. 96:392-397, (Feb. 18), 1967.

Autopsy findings and other features in 16 fatal cases of infantile

removes the mental blur



that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.
Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s

Solfoton Capsules (yellow and brown)
100s, 500s, 1000s

Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

ABSTRACTS, BOOKS

Continued

diarrhea associated with enteropathogenic *Escherichia coli* infection are discussed. The median age at the first positive stool culture was 4.8 months, the two youngest being 16-day-old infants and the oldest 22 months. Almost half the cases were under four months and one third under two months of age. Pathological changes in the gastrointestinal tract were meager and non-pathognomonic. The finding of fatty metamorphosis of varying degrees in the liver in all of the cases is probably associated with either a state of premalnutrition or actual malnutrition of the infant. Severe respiratory tract infection was the leading terminal cause of death. Enteropathogenic *E coli* serotype 0111:B4 was the prevalent offender.

PREVALENCE AND PATHOLOGICAL CHANGES OF ISCHEMIC HEART DISEASE IN A HARD-WATER AND IN A SOFT-WATER AREA

T. Crawford (St. George's Hospital Medical School, London) and M. D. Crawford

Lancet 1:229-232, (Feb. 4), 1967.

A comparison was made of cardiac lesions found in a very soft water area and in a very hard water area in two comparable series of medicolegal necropsies, men who had died from an accident and men who had died suddenly and unexpectedly from ischemic heart disease. In the accident series the prevalence of myocardial scars (healed infarcts) was greater in the soft than in the hard water area. At ages 30 to 44 there was more atheroma and there were

more cases with lumen stenosis in the soft water area. The findings in both of these series suggest an increased susceptibility of the myocardium of patients living in the soft-water area.

CHROMOSOME ANOMALIES AS A CAUSE OF SPONTANEOUS ABORTION

D. H. Carr (University of Western Ontario, London, Ontario)
Amer. J. Obstet. Gynec. 97:283-293, (Feb. 1), 1967.

Chromosome analysis for 227 unselected spontaneous abortions showed that 50 of the specimens had cells with chromosome anomalies. This incidence of 22% is more than 50 times as high as that in live-born infants. Over half the abnormal specimens had one extra chromosome, one fourth lacked a sex chromosome (XO), and the remainder produced cells with whole extra sets of chromosomes. No chromosome anomalies were detected in tissue from 51 induced abortions, ectopic pregnancies, and stillborn infants.

INTRAUTERINE FETAL TRANSFUSIONS FOR ERYTHROBLASTOSIS

R. F. Friesen et al. (Department of Obstetrics, Gynecology, and Pediatrics, University of Manitoba, Winnipeg)

Amer. J. Obstet. Gynec. 97:343-349, (Feb. 1), 1967.

One hundred intrauterine transfusions were attempted on 50 fetuses based on the mother's past obstetric history and antibody titers, but mainly on spectroscopic examination of the amniotic fluid. Transfusions were given between 22 and 32 weeks' gestation. Of 47 fetuses transfused, 19 were born alive and 15 have survived. The operative mortality rate is calculated at about 15% to 20%.

HYPERBARIC OXYGENATION IN THE MANAGEMENT OF GAS GANGRENE

O. H. Trippel et al. (Northwestern University Medical School, Chicago)

Surg. Clin. N. Amer. 47:17-27, (Feb.), 1967.

Twenty-three patients with gas gangrene due to *Clostridium perfringens* were treated with hyperbaric oxygenation, utilizing 100% oxygen at three atmospheres pressure. Seventeen (74%) survived. Recurrence of gas gangrene was not observed after hyperbaric oxygenation was discontinued. Systemic toxicity disappeared rapidly and local spread of the gangrenous infection was quickly arrested following hyperbaric oxygenation. Extensive debridement is no longer necessary. Except for occasional fasciotomy, surgery should be delayed until hyperbaric oxygen is initiated.

SPONTANEOUS MEDIASTINAL AND SUBCUTANEOUS EMPHYSEMA COMPLICATING BRONCHIAL ASTHMA

C. d'Assumpcao and W. G. Smith (Sir Charles Gairdner Hospital, Perth, Australia)

Med. J. Aust. 1:328-330, (Feb. 18), 1967.

Six young adult patients are described in whom spontaneous emphysema was associated with bronchial asthma; two patients had a precordial "crunch" (Hamman's sign). The condition is less rare than is usually believed; it may mimic other conditions, such as myocardial infarction, acute pericarditis, pleurisy, aortic dissection, esophageal rupture, or pulmonary embolism. Slight mediastinal emphysema may be difficult to detect on a chest radiograph but the development of subcutaneous emphysema readily draws attention to this complication of asthma. Active treatment is rarely necessary.

Automobile Leasing

All Types Available

12 Months or Longer

If You Want To

Know The Facts

CONSULT OUR SPECIALISTS

Phone 317-253-4415

Quality Leasing, Inc.

6310 GUILFORD AVE.

INDIANAPOLIS, IND.

PERFORATED PEPTIC ULCER

J. E. Devitt and G. A. Taylor (402 Central Medical Building, 1105 Carling Ave., Ottawa)

Canad. Med. Assoc. J. 96:519-523, (March 4), 1967.

A series of 402 cases of perforated peptic ulcers from the Ottawa Civic Hospital was reviewed to determine the nature of this dramatic disorder as seen in Canada. The incidence was 15 per 100,000 population annually or one in every 1,000 hospital admissions. The relative incidence in females and the elderly was higher than reported elsewhere. The risk of perforation increased with age, being greatest after 55. This was not due to an excess of chronic ulcers in older patients, indicating that aging is a factor in the etiology. Since mortality was unchanged at 20% over the years, the deaths were studied to see if change in management seemed appropriate. Mortality for those patients who underwent operation was 7.5%. All patients treated conservatively because of poor condition died. Fifteen deaths occurred in misdiagnosed patients.

NEED FOR GLUCAGON IN SEVERE HYPOGLYCEMIA INDUCED BY SULFONYLUREA DRUGS

D. M. Davies et al. (Briarsyde, Queens Rd., Blackhill, Consett, England)

Lancet 1:363-364, (Feb. 18), 1967.

In a fatal case of poisoning with a large self-administered dose of chlorpropamide, the blood glucose level was not raised to normal until glucagon was given in addition to glucose. Glucagon should always be given in addition to glucose in severe hypoglycemia induced by sulfonylurea drugs.

SCIENTIFIC SHOE FITTING

Since shoes are the foundation for the entire body they deserve scientific fitting as to the person's size, last and foot shape.

If abnormalities exist we apply arches, metatarsal bars, wedges, Thomas heels and the necessary shoemaking alteration to encourage helpful function of the foot and limbs. Only then can the shoe enable proper stance, posture and walking satisfaction for man, woman, child.

This service is assured by experienced shoe fitters and trained Orthopedic shoemakers. Both must work together to get the best results. A pharmacist compounds a prescription so should a professional shoe fitter make applications for shoe corrections.

Heid's follow up service during the life of the shoe is also of utmost importance since the response may differ with each individual. Often a slight alteration makes for lasting comfort and satisfaction.

This scientific shoe fitting and corrective application is a service offered by Heidenreich and Son who operate the **Heid's Health Shoe Store** at 411 N. Illinois St., Indianapolis, Indiana.

Your referrals and prescriptions will receive accurate, conscientious attention at reasonable, ethical charges. No job too big, none too small.

"COCA-COLA" AND "COKE" ARE REGISTERED TRADE-MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY.



From The Journal 50 Years Ago

. . . It may be said without fear of contradiction that not enough attention is paid by physicians in general to the subject of nutrition. It may even be said that there is but very little known about the science of nutrition by the average general physician. Yet this subject is always of great importance to the physician, and, in these days, it is of paramount importance not only to the profession but to all humanity.

Questions relating to nutrition are not often put up to the physician by healthy individuals. The latter in health decide such questions for themselves. Since there is so much general ignorance with reference to nutrition, errors are quite common. It is very well known that usually people everywhere — especially in this country — eat too much. The consequences of such over-eating are manifested by various digestive disturbances and the associated disturbances or changes resulting therefrom. That such disturbances and changes are numerous every clinician of experience knows. On the other hand, individuals who subsist on a diet properly selected and regulated according to the principles of scientific nutrition are entirely free of all such disturbances and symptoms, and seem to be much more vigorous in every way than those in the former class. . . . Editorial, JISMA, October, 1917.

APPLICATION FOR TERM LIFE INSURANCE
to PROFESSIONAL LIFE & CASUALTY COMPANY, CHICAGO, ILLINOIS

1. Full Name of Applicant

Date of Birth

Mo. Day Year

Place of Birth

City

State

2. Height

Weight

3. ☐ Male, ☐ Female

4. ☐ Married, ☐ Single, ☐ Divorced, ☐ Separated

5. PERMANENT MAILING ADDRESS:

Street Address

City

State

Zip

No. of Yrs.

6. Medical School:

Name

City & State

Date Entered Medical School

7. AMOUNT OF INSURANCE: 10 YEAR CONVERTIBLE* TERM

OR 15 YEAR CONVERTIBLE* TERM

☐ \$10,000.00

☐ \$20,000.00

☐ \$10,000.00

☐ \$20,000.00

*Convertible to participating Whole Life Insurance at any time prior to the end of the Term period.

8. PREMIUMS PAYABLE: ☐ Annually ☐ Semi-Annually ☐ Other

Premium: \$

9. DISPOSITION OF ANNUAL DIVIDENDS: ☐ Pay in Cash ☐ Accumulate at Interest ☐ Apply to Premium

10. Beneficiary

Name in Full

Relationship

11. Do you know of any impairment now existing in your health or physical condition?

Yes

No

If "yes" give particulars

12. Have you consulted a physician for illness during the past three years?

Yes

No

If "yes" give particulars

I HEREBY APPLY for insurance described above and agree to pay premiums therefor at the rate shown above.
INFORMATION in this application is given to obtain this insurance and is true and complete to the best of my knowledge and belief. The Company shall incur no obligation because of this application unless and until it is approved by the Company and the first premium is paid in full while in health or other conditions affecting my insurability are as described in the application.

Start your program of insurance protection today, while premiums are low with a Term-Life Plan that meets today's needs with a protective look towards the future.

Professional Life & Casualty Company which has made a career of serving the life and disability insurance needs of members of the medical community introduces its new Guaranteed Convertible Term-Life Plan developed for students, interns and residents who are commencing a career in the medical profession.

This plan is designed for maximum protection with a nominal premium you can afford, prior to your productive earning years.

The low annual premium provides a level amount of life insurance during a period when you may have real need for the financial protection and benefit of your family and dependents or of anyone financing your education.

ANNUAL DIVIDENDS

This is a 'participating plan' which means you participate in annual dividends to policyholders. You may elect to have your Annual Dividends *paid in cash*, applied to reduce your annual premium or accumulated at interest (see item 9 of application).

LOW, FIXED ANNUAL PREMIUM

Your Annual Premium is based on your age at issue (nearest birthday) and remains the same for the duration of the policy. *It cannot be changed by the Company.*

NON-DECREASING COVERAGE

You may select either \$10,000 or \$20,000 of life insurance. Your insurance will continue for the amount and term you select (10 year or 15 year term period) and *cannot be reduced or terminated by the Company.*

GUARANTEED CONVERSION

Your term policy may be converted to our Participating Whole Life Plan at any time during the policy period *without any restrictions or limitations.*

THE IMPORTANCE OF CONVERSION TO PLC's PARTICIPATING WHOLE LIFE PLAN

Your Term Plan guarantees you the right to obtain PLC's participating Whole Life Plan which has been rated the No. 1 "low net cost" plan by a nationwide statistical service.

The rating was based on comparisons with similar plans issued by the 25 largest U. S. life insurance companies as well as with similar plans issued by the 100 lowest 'net cost' life insurers in the nation.

Pick your own plan and compare! Prove it to yourself that here is a maximum protection plan you need . . . and you can afford.

GUARANTEED CONVERTIBLE TERM INSURANCE				
Premiums for \$10,000 POLICY				
Age At Issue (Nearest Birthday)	10 YEAR TERM		15 YEAR TERM	
	Annual	Semi-Annual	Annual	Semi-Annual
21	\$33.00	\$17.00	\$34.00	\$17.50
22	33.50	17.50	34.50	18.00
23	34.00	17.50	35.00	18.00
24	34.50	18.00	35.50	18.50
25	35.00	18.00	36.00	18.50
26	35.50	18.50	36.50	19.00
27	36.00	18.50	37.50	19.50
28	36.50	19.00	38.50	20.00
29	37.00	19.50	40.00	21.00
30	37.50	19.50	42.00	22.00

—Premiums for \$20,000 Policy are double the above rates
—Premiums for Ages not shown will be provided on request



Professional Life & Casualty Company

HOME OFFICE: 720 N. Michigan Ave., Chicago, Illinois 60611

CHAIRMAN—Edwin S. Hamilton, M.D.
PRESIDENT—Edward L. Compere, M.D.
GENERAL MANAGER & ACTUARY—
Norman R. B. King
ASSOC. MED. DIR.—E. Clinton Texter, Jr., M.D.



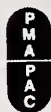
Now we have a Term-Life Plan
with premiums you can afford,
designed for conversion to
permanent life protection.

New drugs take exams, too.

Today, virtually every medical school in the United States cooperates with pharmaceutical manufacturers in the clinical evaluation of new and promising drugs. Just as you might find it significantly more difficult to practice medicine without the useful new compounds made available through original pharmaceutical research in the past twenty years—prescription-drug manufacturers would find it equally difficult to obtain extensive, long-term, dependable evaluations of new therapeutic agents without the close cooperation of medical staffs and clinical

facilities of medical schools and teaching hospitals. Such cooperation leads toward more effective care of more patients—the common goal of medical and pharmaceutical research—toward reduction in the cost of disease, toward increase in useful longevity.

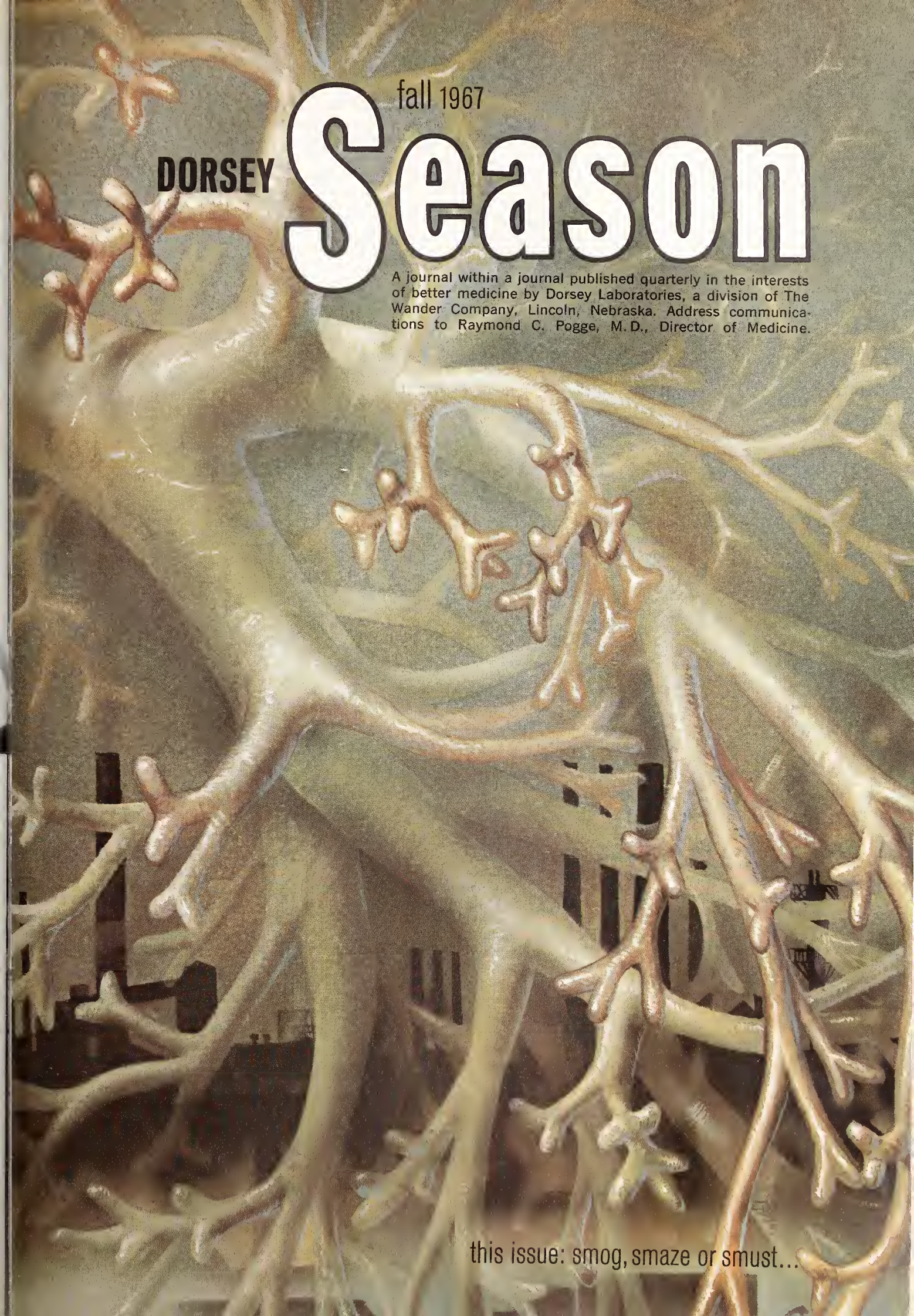
This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.



**Pharmaceutical
Manufacturers Association
Pharmaceutical
Advertising Council**

1155 Fifteenth St., N. W., Washington, D.C. 20005





fall 1967

DORSEY

Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M.D., Director of Medicine.

this issue: smog, smaze or smust...

Smog, smaze or smust...effects of air pollution on upper respiratory tract

Nathan Flaxman, M.D., Diplomate, American Board of Internal Medicine, Chicago, Illinois

In Los Angeles it is *smog* (smoke and fog). In New York City *smaze* (smoke and haze). In El Paso *smust* (smoke and dust). The original factor was smoke plus such natural phenomena as fog, haze and dust, but air pollution has mushroomed from a smoke problem in our industrial cities into a major economic, esthetic and public health problem that affects practically every American locality and citizen.^{1,2} Respiratory disease, of course, is by far the most costly effect of air pollution, for contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.¹

The greatest problem in dealing with solid wastes is that they are not quickly returned to dust. To aid the decomposing process, the great bulk of such waste is burned, polluting our air in the process.³ Dr. Jack McKee of the California Institute of Technology⁴ has calculated that in Los Angeles County, which has more than six million people, about three pounds of gaseous wastes per person per day (on a dry-weight basis) enter the atmosphere. This is twice as much as solid refuse disposal and six times as much as the contaminants in waste water. It is estimated that in New York City, 730 pounds of pollutants, a little over half the size of a compact two-door sedan of foreign make, is annually thrown into the air for each man, woman and child in the city.⁵

Air pollution is an evident factor, not only in the common cold and upper respiratory disease, but also in chronic bronchitis,² pulmonary emphysema,⁶ bronchial asthma,⁷ pneumonitis and lung cancer.⁸ Its effect on the incidence of pulmonary tuberculosis is unproved,⁹ although it is conceivable that the

presence of various materials polluting the air might do this. A siege of smog in Denver, the "mile high city," in December 1965 was accompanied by respiratory infection that doubled normal absentee rates in schools, factories and city government.¹⁰

While air pollution is only one factor, it has become important in the causes of most of the afflictions of the respiratory tract. This has been shown not only by the Denver occurrence, but also by detailed study of respiratory illness in a small group of 313 men



from October 1962 to May 1963 when there were 202 episodes involving the upper respiratory tract. The attack rate of illness was related in time to increased concentration of both smoke and sulphur dioxide in the atmosphere of the district in which the men lived.

Other factors often mentioned, include exposure to those who have colds, exposure to extreme changes of temperature, allergy and bacterial infection. However, when low individual resistance due to lack of rest, overwork, fatigue, improper or unbalanced diet, previous illness and emotional stress are included as causes, we enter the realm of somewhat obscure relationships. Much more emphasis can be placed on the role of polluted air.

The symptoms, signs and complications of involvement of the upper respiratory tract, especially the common cold, are the same regardless of the causative factor. Swelling of the lining of the nose, the scratchy dry throat, the discharge from the nose at first watery then thicker, discolored and more tenacious, the eyes tearing, and frequent sneezing are all part of the Number 1 human ailment. Concurrent or residual sinusitis when mucus is trapped there, middle ear involvement due to interference with drainage, laryngitis and bronchitis are complications of the common cold. The primary interference is with a most important function of the nose—the cleansing of foreign matter in the first line of ‘air defense’ to prevent it from entering the breathing tract.

However, the diagnosis and subsequent decision on how to treat the patient so affected rests basically on the relief of symptoms that cause him the misery. The stuffed, runny nose, the clogged ears, and the harsh dry cough—all the symptoms that make common cold sufferers feel miserable and interfere with their sleep—can be alleviated with medications of the oral nasal decongestant/antihistamine combination type. The burning sensation in the throat, sore-

For nature’s hazards:
nasal congestion
due to seasonal
allergies and
summer colds



Triaminic® syrup

Each teaspoonful (5 ml.) contains:

Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting comfort to your little patients with Triaminic Syrup. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

ness of the chest and even chest pain can also be relieved by such medication. Rest in bed if there is fever (but confined to home at least), liberal fluids, uniformly warm surroundings and adequate humidity in the room, are all helpful adjuncts to the medication. Most common cold sufferers recover rapidly and are symptom-free in four to ten days.

Further treatment, altered by the fact that the affliction hangs on for more than the usual duration of the common cold, requires consideration of allergy, which is most frequently the prolonging factor. But air pollution itself may often be the culprit.

(Concluded on following page)



at the Third National Conference on Air Pollution held recently, it was emphasized that this subject had received more attention in the past four years than in all previous history. Spicer,¹¹ an active participant at this conference, reiterated that it behooves the practicing physician to be aware of trends in respiratory disease and to accept a major role in community action relating to air pollution and respiratory health. By taking a positive stand physicians have been instrumental in the development of anti-pollution legislation. An outstanding example is Los Angeles where major steps have been taken by abolishing coal burning, and even banishing oil burning, seven months a year. Natural gas must be used instead and it must be used by industry when available. Backyard incinerators have been abolished in favor of landfill disposal, and building incineration ended except for a few expensive smokeless furnaces.¹⁰ Concerted action can be taken against particular industrial nuisances. One company that disregarded complaints discovered its error when thousands of its credit cards were returned by irate customers who decided to patronize competing companies.¹²

Summary. Respiratory disease is the most important and most costly effect of air pollution, whether termed smog, smaze, or smust. Air pollution is an economic, esthetic and public health problem that affects practically every American locality and citizen. New sources of air pollution are invisible and odorless, but the harmful gases and liquid droplets are there. Triggered by sunlight, some of these undergo mid-air chemical changes and the results are even more irritating to the upper respiratory tract. The symptoms, signs and complications, especially of the upper respiratory tract, can be readily aborted by modern medication but may be unduly prolonged by polluted air. In steps taken to prevent this, the practicing physician can take a major role.

References

1. Anderson, R. J. Air Pollution, Respiratory Disease and the NTA, W. Virg. M. J., 60:332, 1964.
2. Angel, J. H., Fletcher, C. M., Hill, I. D., and Tinker, C. M. Respiratory Illness in Factory and Office Workers, Brit. J. Dis. Chest, 59:66, 1965.
3. Waste Disposal Problems Grow, Current Municipal Problems, 8:218, 1966.
4. McKee, J. quoted by Hills, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966.
5. NYC Task Force Revives Concern on Air Pollution, Med. Trib. 7:23 (Sept. 17-18) 1966.
6. Flaxman, N. Pulmonary Emphysema, Med. Trial Tech. Quart. 1960 Annual, p. 221.
7. Heimann, H. Air Pollution and Respiratory Disease, Ann. Allergy 21:396, 1963.
8. Flaxman, N. Pneumonitis and Lung Cancer, Med. Trial Tech. Quart. 1965 Annual, p. 185.
9. Flaxman, N. Pulmonary Tuberculosis, Occupation and Trauma, Med. Trial Tech. Quart. 1959 Annual, p. 237.
10. Hill, G. U.S. War at Home-Fight Against Smog, Chicago Tribune, Sept. 26, 1966.
11. Spicer, W. S., Jr. Relation of Air Pollution to Disease, Arch. Environ. Health, 9:600, 1964.
12. Henderson, C. F. What You Can Do To Combat Air Pollution, Parents' Mag. 41:76, 1966.

How can he be a sport with a runny nose?



For summer allergies, summer colds, or nasal congestion due to almost any cause, you prescribe quick r-e-l-i-e-f with Triaminic. It's ideal for summer allergies:

1. Acts in 15-30 minutes due to decongestant.
2. Follows up with balanced dual antihistamines.
3. Up to 24-hour 'round the clock relief when dosed one tablet at morning, midafternoon and evening.

Summer time is sport time and who can be a sport with a runny nose?

provide patient comfort

Triaminic® relieves
summer allergies

Each timed-release
tablet contains:

Phenylpropanolamine hydrochloride	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitation, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

(Advertisement)



DR. GARY TOWNSEND SPEAKER FOR HISTORY OF MEDICINE SOCIETY MEETING

Dr. Gary Townsend, of the Indiana University Medical Center, will speak at the November 8 meeting of the John Shaw Billings History of Medicine Society. His topic will be "Report on the 1967 AAHM Meeting, Yale Medical School."

The group meets at the I.U. Student Union Building, Indianapolis. The social hour begins at 6:00 p.m., dinner at 6:45 and the speaker at 8 p.m.

Drs. Lampe and Doermann are Speakers

Drs. Elfred H. Lampe, Fort Wayne, and Paul E. Doermann, Huntington, gave speeches recently at a colloquium on medical ethics sponsored by the Lutheran Academy for Scholarship.

Dr. Lampe discussed "Abortion and Sterilization: Medical Aspects" and Dr. Doermann talked on "Tissue and Organ Transplants: A Medical View."

New Emergency Health Care Film Now Available to Physicians

A 40-minute color film, "Hands of Action," depicting recommended procedures for handling a number of emergency health care situations is now available on a free loan basis from the Public Health Service.

The film, designed for use by instructors conducting training programs for operators of emergency vehicles, outlines recommended procedures for emergency handling of blocked airways, bleeding, open wounds and broken bones.

The film depicts a physician, using layman's language, instructing ambulance attendants. He describes the nature of the respiratory and circulatory systems, dangers of infection and the types of broken bones attendants might encounter. Demonstrations that focus on both real and simulated injuries emphasize proper procedures to enable the attendant to transport the patient without further injury.

The 16 mm. optical sound film was produced by the Trauma Committee of the North Carolina Chapter of the American College

of Surgeons under a Community Health Services project grant from the Public Health Service.

Write Regional Program Director, ICP, Public Health Service, DHEW, 433 W. Van Buren St., Chicago 60607.

Dr. Miller Honored

Dr. W. A. Miller was honored this summer by the citizens of Hagerstown where he has practiced general medicine for the past 40 years. A community gathering at the Hartley Hills Country Club, at the conclusion of Dr. Miller's customary weekly golf game, presented him with a Harley Davidson golf cart, and collectively expressed their appreciation for his many years of faithful practice, part of the time as the town's only practitioner.

Drug Industry, Riker Laboratories Honored for Contributions

Dr. William Van Valin, chairman of the Direct Relief Foundation and the National Council of AMDOC, has hailed the pharmaceutical industry as the "unsung heroes behind the Direct Relief program, which is shipping some \$12 million worth of American drugs annually to some 25 million medically worthy persons in 50 foreign countries."

Dr. Van Valin, formerly associated with Dr. Albert Schweitzer in Africa and Dr. Tom Dooley in the Far East, presented Riker Laboratories, the ethical pharmaceutical division of Rexall Drug and Chemical Company, with a certificate honoring the company for its contribution to the medically underprivileged around the world.

Dr. Kerner in Viet Nam

Dr. Donald J. Kerner, resident in general practice, Methodist Hospital, Indianapolis, is on temporary duty in Viet Nam as a part of the AMA Volunteer Physicians program.

National Fire Protection Association Announces Availability of Pamphlets

The National Fire Protection Association announces the availability of NFPA pamphlets of interest to hospitals and other facilities for care of patients.

"Standard for Nonflammable Medical Gas Systems (28 pages), 50 cents; "Standard for Essential Electrical Systems for Hospitals" (24 pages), 50 cents; "Tentative Standard for Inhalation Therapy" (28 pages), 75 cents; "Recommended Good Practice for the Maintenance and Use of Portable Fire Extinguishers" (44 pages), 60 cents; "Code for Safety to Life from Fire in Buildings and Structures" (228 pages), \$1.50; "Standard for the Protection of Records" (100 pages), \$1.00; and "Standard for the Installation of Portable Fire Extinguishers" (44 pages), 60 cents. The address is 60 Batterymarch St., Boston 02110.

Dr. Heasty Is Speaker

Dr. Alfred R. Heasty, West Lafayette, spoke on "LSD: Fact and Fiction" at a recent meeting of the Vigo County Association for Mental Health.

State Medical Education Board Named

Dr. Joseph M. Black, Seymour, Dr. Jack H. Hall, Indianapolis, Dr. Glenn W. Irwin, Jr., dean of the I.U. School of Medicine, and Dr. Andrew C. Offutt, State Health Commissioner have been appointed by Governor Roger D. Branigin to the new Medical Education Board. The board was created by the 1967 Indiana General Assembly to authorize the Indiana University School of Medicine to set up regional intern-

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

W.M. P. POYTHRESS & CO., INC.
 RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

NEWS NOTES

Continued

ship-residency programs.

Governor Branigin also appointed Dr. Black to the Indiana Tuberculosis Council.

Drs. Kitt and Hammond Lecture

Drs. Walter Kitt and Stanley Hammond, Munster, Ind., gave lectures recently for Calumet region nurses. Dr. Kitt spoke on "Dynamics of Neurosis and Depression" and Dr. Stanley spoke on "Newer Developments in the Study of Dreaming and Sleep."

Royal Society of Medicine Foundation Established in U. S.

The Royal Society of Medicine Foundation has been established in the United States by joint effort of the Royal Society of Medicine (London) and members of the medical profession of the U. S. to establish closer relations between members of the profession of Great Britain and United States.

Tax-deductible contributions to the Foundation will be used to improve facilities for medical research and education, as well as to provide medical scholarships, to sponsor conferences for the exchange of information on medical research and to preserve medical literature. The Foundation's address is 20 Broad St., New York City 10005.

Mr. Miles Retires

Charles F. Miles, senior vice-president, Miles Laboratories, Elkhart, Ind., retired on September 1. He will continue as one of the firm's directors.

Physician Appointments Announced by Dow Laboratories

Dr. Robert Nolan, a graduate of Creighton University School of Medicine, has been appointed as Director of Clinical Pharmacology for the Dow Human Health Research and Development Laboratories at Pitman-Moore.

Dr. Lawrence J. Milch has been promoted to the position of Assistant Director of Dow Human Health Research and Development. Dr. Anton J. Schwarz, director, announced that Dr. Milch will be responsible for technical direction of research and development activities in the laboratories.

Dr. Malcolm Chamberlain will work as Administrative Assistant to the director of Dow Human Health Research and Development. All three will be located at the Pitman-Moore laboratories near Indianapolis.

Dr. Girod Speaks

Dr. Arthur H. Girod, Decatur, Ind., spoke on Vietnam and American aid at a recent Decatur Rotary Club meeting.

New Pitman-Moore Managers

J. Edward Lowery, a native of Indianapolis, and a 1953 graduate of Purdue in pharmacy, has been appointed as Salary Administration Manager for Pitman-Moore.

Martin Feinberg of Pitman-Moore has been promoted to the position of Manager, Sales Development of Hospital Products. He will have headquarters in Indianapolis.

Dr. Lloyd Gives Talk

Dr. Frank Lloyd, Indianapolis, spoke recently to members of the Central Indiana Dietetic Association on current research in this field.



GOLDEN ANNIVERSARY GRADUATES—Thirteen of 16 surviving physicians who were graduated 50 years ago from Indiana University's School of Medicine were present for alumni day festivities on the school's Indianapolis campus recently. The 1917 graduates represented the largest percentage of any class ever to be present on alumni day. They are (front row, left to right) Dr. Harrison A. Walker, Miami, Fla.; Dr. Dwight H. Murray, Napa, Calif.; Dr. Martin L. Marquette, Vallejo, Calif.; Dr. John L. Glendening, Indianapolis; Dr. Chester N. Frazier, Chapel Hill, N.C.; and Dr. Edwin G. Nelson, Minneapolis, Minn. Standing (left to right) Dr. Karl M. Koons, Indianapolis; Dr. John R. Frank, Indianapolis; Dr. Lyman Overshiner, Columbus; Dr. Fowler B. Roberts, Akron, O.; Dr. Reuben A. Solomon and Dr. Roy L. Smith, both of Indianapolis. The 13th, Dr. Horace R. Willan, Martinsville, arrived after the photo was taken. (Star Photo)

Dr. Ebert Named

Dr. William R. Ebert, Director of Research and Development for Philips Roxane Laboratories, will also serve as Vice President of Research and Product Development for Alliance Laboratories which was established recently to manufacture and distribute generic drugs.

Dr. Ebert will be responsible for all technical aspects of the company and will maintain liaison with the FDA.

Dr. Sheehan Becomes Fellow

Dr. E. Gregg Sheehan, Evansville, was installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting in Washington.

New Research Underwritten by The Upjohn Company Grants

New research to determine more precisely how and why drugs work within the human body will be underwritten by \$1,525,000 in grants The Upjohn Company is making to three medical schools. The University of Michigan will develop the nation's first clinical pharmacology center.

Harvard University Medical School will establish a professorship in clinical pharmacology, and Vanderbilt University Medical School will develop new laboratory space for clinical pharmacology.

Dr. Kesim Attends Course

Dr. Mufit H. Kesim, Elkhart pediatrician and director of the Elkhart Cystic Fibrosis Clinic, recently attended a 10-day training period in Cleveland on new methods of treating cystic fibrosis.

Dr. Bibler Visits Europe

Dr. and Mrs. Lester D. Bibler, Indianapolis, recently returned from a trip to Europe. Dr. Bibler visited the College of General Practice of England and also attended the Premiere Congress of the College of France of Vascular Pathology.

Dr. Green Named

Dr. Morris Green, Indianapolis, has been named a member of a national task force studying the mental health needs of children.

Dr. Earl Conducts Program

Dr. Max M. Earl, Kokomo, recently presented films on "Cancer and Two Women" and "Breast Self-Examination" and answered questions about cancer at an open meeting at the Maple Crest School at Kokomo.

Dr. Snowwhite Is Speaker

Dr. Arthur B. Snowwhite, Marion, explained the eye bank program to members of Recent Grads of the American Association of University Women during a recent meeting in Marion.

Dr. Brandman Is Seminar Speaker

Dr. Harry Brandman, Gary, recently spoke on "Peptic Ulcers" during a seminar at Gary's Mercy Hospital.

Dr. Bankoff Appointed

Dr. Milton L. Bankoff, Michigan City, was recently appointed by the U.S. Public Health Service to the position of deputy chief, Nursing Homes and Related Facilities Branch, Division of Health Care Services.

NEWS NOTES

Continue

sion of Medical Care Administration.

Dr. Bankoff will be in charge of research grants for convalescent-type institutions across the country. He also will direct the development of the best possible programs for converting custodial homes into extended-care facilities.

Dr. Klassen Is Speaker

Dr. Otto D. Klassen, Elkhart, recently spoke on "Thought Versus Feelings — An Unequal Struggle" before a meeting of the Elkhart Oaklawn Auxiliary.

Dr. Lloyd Elected

Dr. Frank P. Lloyd, director of medical research at Methodist Hospital, Indianapolis, has been elected president of the Metropolitan Plan Commission.

Drs. Neifert and Ress on Panel

Drs. Noel Neifert and Gene Ress, Tell City, recently participated in a panel discussion on "Your Child's Health" at a meeting of the Lincoln Hills Forum.

Dr. Kuhn Honored

Dr. Hedwig S. Kuhn, Munster, recently was guest of honor at the celebration of the centennial of the birth of her father, the late Professor Julius Stieglitz, a noted chemist. Dr. Stieglitz helped establish the University of Chicago's chemistry department in 1895.

Dr. Matthew Is Speaker

Dr. W. Burleigh Matthew, Indianapolis, recently spoke at Howell Methodist Church, Evansville, on the eye clinics and hospitals he has established in India. Dr. Matthew arranges for supplies to be sent to the hospitals in India and he and his wife have made three working trips there.

Dr. Whitlock Appointed

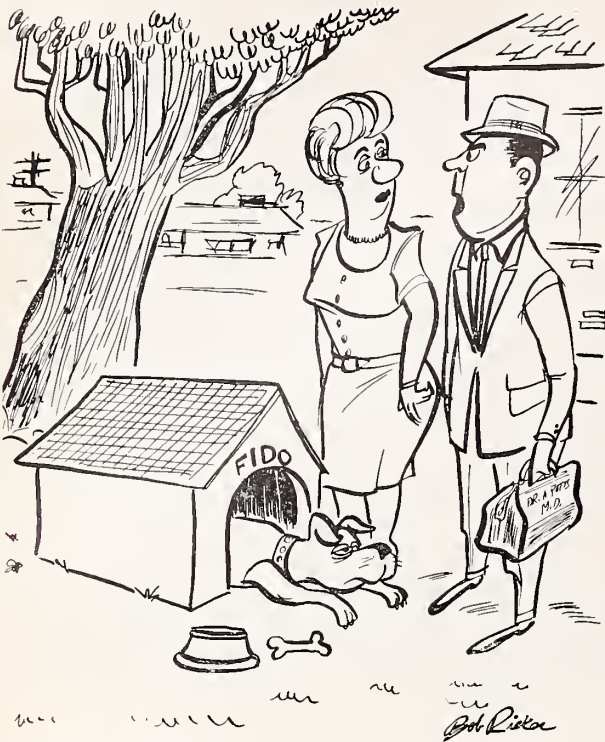
Dr. Merle E. Whitlock, Mishawaka, has been named medical director of the Wheelabrator Corp. in South Bend.

Dr. Ferguson Takes Office

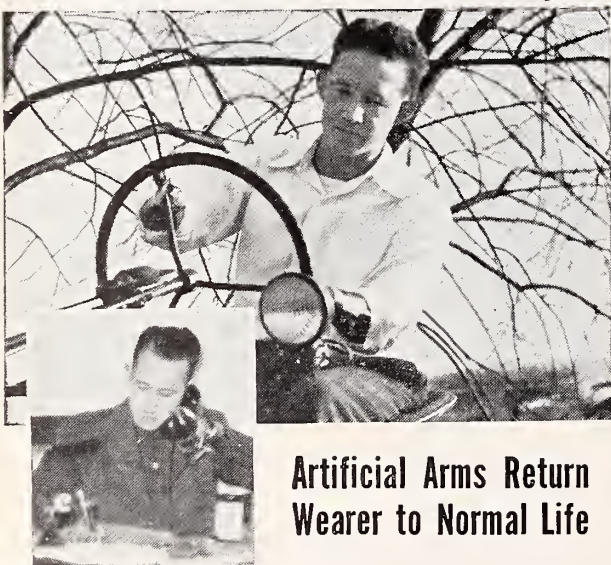
Dr. William B. Ferguson, Lafayette, recently took office as president of the Greater Lafayette Chamber of Commerce.

Two decades ago, a hospital employed a worker and a half for every patient it served. Today, the ratio is three-to-one. There is a parallel in the entire American system of health care: In 1940 there were five health workers for each physician; in 1950, there were seven; and in 1960, there were 11 such individuals for each doctor. Today there are 13 health workers for each physician, and by 1970, there will be a ratio of 17-to-1 by every reliable indicator.

JOURNAL of the Indiana State Medical Association



By house calls, madam, we don't mean dog house!



Artificial Arms Return Wearer to Normal Life

Dwight McGee of Lancaster, Ohio, wearing two Hanger Arms, can write, shave, use a knife and fork, drive an automobile, and says he can do about anything an ordinary person can do. Hanger Arms are custom-made to fit the wearer's stump and his particular daily needs, and are carefully fitted by experienced Hanger fitters. Arms can be furnished with cosmetic or mechanical hand and hook.

Hanger
PROSTHETICS

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac St., Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

FUTURE MEETINGS, SEMINARS, COURSES

"Clinical Allergy and Immunology" Course Offered on November 8

The third annual "Frontiers of Medicine" series will present a course on "Clinical Allergy and Immunology" November 8 at the University of Chicago Hospitals and Clinics.

Further details on the programs and information on registration may be obtained by writing David M. G. Huntington, Administrative Coordinator, Committee on Continuing Medical Education, the University of Chicago, 950 E. 59th St., Chicago 60637.

"Problems In Pelvic Surgery" Course Listed for November 8-9

A course on "Problems in Pelvic Surgery" will be conducted at the Cleveland Clinic Educational Foundation on November 8 and 9.

Further information and programs may be obtained by writing Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland 44106.

Postgraduate Course on "Modern Concepts of Allergy" in Colorado

The University of Colorado School of Medicine will conduct a postgraduate course on "Modern Concepts of Allergy" December 6 through 8 in Denver.

The fee will be \$60.00. Write Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

American College of Surgeons Three-Day Sectional Meeting

The American College of Surgeons will hold a three-day sectional meeting in Dallas February 19 to 21, 1968. It is open to all physicians.

About 100 surgeons will conduct panels, symposia, "How-I-Do-It" Clinics, show films and give lectures on all phases of surgery and all the surgical specialties. For copies of the program write the College at 55 E. Erie St., Chicago 60611.

First Biennial Symposium on Management of Trauma, Disaster

The First Biennial Symposium on the Management of Trauma and Disaster Medical Problems will be conducted by the AMA at Miami Beach on November 10 and 11, at the Carillon Hotel.

Two general sessions, one workshop period and a panel discussion are scheduled. The program is acceptable for 12 accredited hours by the American Academy of General Practice.

American College of Gastroenterology 32nd Annual Convention in Los Angeles

The American College of Gastroenterology will hold its 32nd Annual Convention at the Biltmore Hotel in Los Angeles on October 29 to November 1.

After the convention there will be a three-day postgraduate course in gastroenterology at the Biltmore.

Aspen Conference on the Newborn Scheduled at Children's Hospital

Children's Hospital, Denver, will present the Aspen Conference on the Newborn at the Aspen Institute for Humanistic Studies on February 5, 6, and 7, 1968.

Morning seminars and discussions will be led by Jerold F. Lucey, M.D., Professor of Pediatrics, University of Vermont; Thomas K. Oliver, Jr., M.D., Professor of Pediatrics, University of Washington; and Edward J. Quilligan, M.D., Professor and Chairman, Department of Obstetrics, Yale University. Afternoons will be open.

Registration fee is \$40.00. Registration will be limited to insure an informal meeting. For further information write: Aspen Conference on the Newborn, Children's Hospital, 19th Avenue at Downing, Denver, Colorado 80218.

Postgraduate Course on Management Of Trauma and Diseases of Spine

A postgraduate course on management of trauma and diseases of the spine will be conducted at Hollenden House, Cleveland, Ohio, on November 27 to 29, by the American Academy of



CLINICAL RESEARCH OPPORTUNITIES for PHYSICIANS

**PITMAN-MOORE DIVISION
THE DOW CHEMICAL COMPANY**

**DOW HUMAN HEALTH
RESEARCH & DEVELOPMENT**

Applicants with good general medical knowledge and strong interest in research sought for expanding research departments. Will organize, arrange and evaluate clinical investigation of pharmaceuticals and biologicals. Research background desirable but not essential.

Excellent salaries commensurate with background. Company paid relocation expenses to Indianapolis.

Send full details of qualifications in strict confidence to:
A. Kaloyanides, Mgr.,
Technical Placement

**PITMAN-MOORE
DIVISION
THE DOW CHEMICAL COMPANY**
1200 Madison Ave.
Indianapolis, Indiana
An Equal Opportunity Employer

FUTURES

Continued

Orthopaedic Surgeons. Western Reserve School of Medicine is cooperating.

Registration fee is \$100.00, which includes three luncheons. Residents and interns will be admitted for \$10.00 by letter from their Chief of Service.

AMA Schedules Conference on "Emergency Medical Services"

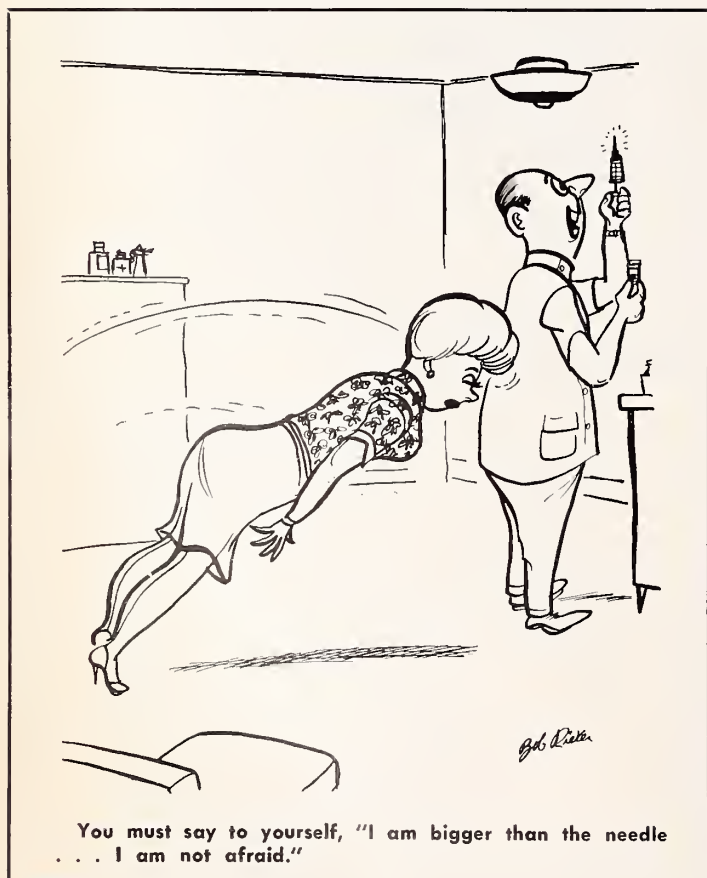
A national conference on "The Community and Emergency Medical Services" will be held at the San Francisco Hilton Hotel, January 18 to 20, 1968 under the auspices of AMA.

For further information write AMA Department of Hospitals and Medical Facilities, 535 N. Dearborn, Chicago 60610.

The Society for Cryo-Ophthalmology Announces Second Annual Meeting

The second annual meeting of the Society for Cryo-Ophthalmology will be held in Miami Beach, January 14 to 18, 1968, with Dr. Jose Barraquer, of Bogota, Colombia, presiding. The program will include a session on retinal surgery, with Dr. Giambattista, of Rome, as the featured speaker. Dr. H. Fanta, of Vienna, will lead the discussion on cryoextraction of cataracts.

Those wishing to present papers at this meeting should submit title and brief abstract to Dr. John G. Bellows, executive secretary, 30 N. Michigan Ave., Chicago, Illinois 60602, at the earliest possible date.



Gastroenterology Postgraduate Course Listed for November 2-4

A postgraduate course in gastroenterology will be conducted by the American College of Gastroenterology at the Biltmore Hotel, Los Angeles, on November 2, 3, and 4.

The subject matter will cover recent advances in both the medical and surgical fields. For further information and enrollment write to the College at 33 W. 60th St., New York City 10023.

"Surgery of the Hand" Postgraduate Course at the University of Colorado

"Surgery of the Hand" will be the subject of a four-day postgraduate course at the University of Colorado School of Medicine in Denver, from February 20 to 23, 1968.

For details write Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

Regents Meeting, Indiana Division Of the International College of Surgeons

The annual regents meeting of the Indiana division of the International College of Surgeons will be held at Bloomington, November 11 at the Holiday Inn on State Road 37, north of that city.

The scientific session will begin at 1:30 p.m. Dr. Ray Smith, Indianapolis, will speak on "Impressions of Medical Practice in Viet Nam"; Dr. George W. Holmes, Chicago, will discuss "Hiatal Diaphragmatic Hernia" and Dr. C. Basil Fausset, Indianapolis, will talk on "Cervical Spine Disc and Associated Conditions." An activity will be planned for the wives in the afternoon.

Following the scientific sessions, there will be a short business meeting, a social hour at 6 p.m. and dinner at 7 p.m. There will be no speakers at the dinner. Entertainment will be provided by the Indiana University Singers.

Contact Dr. Philip T. Holland, 406 S. College Ave., Bloomington, for reservations.

"Current Concepts In Cardiology" Subject of Postgraduate Program

"Current Concepts in Cardiology" is the subject of a postgraduate program offered by the Institute for Cardiovascular Diseases of Good Samaritan Hospital, Phoenix, Arizona, on January 10, 11 and 12, 1968. Meetings will be at Del Webb's Towne House.

This is an official postgraduate course of the American College of Cardiology. Write Mr. William B. Nelligan, American College of Cardiology, 9650 Rockville Pike, Washington, D. C. 20015 for further information.

Diabetes Association of Greater Chicago 10th Annual Symposium

The Diabetes Association of Greater Chicago will conduct its Tenth Annual Symposium on Diabetes at Northwestern University Medical Center, Thorne Hall, 740 Lake Shore Drive, Chicago, Illinois on Friday, November 10 with registration beginning at 8:30 a.m.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members and dietitians. The fee for non-members is \$10. If membership in our association is desired and approved, this fee would cover the 1968 payment.

Inquiries may be addressed to: The Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago 60611.

County, District News

Dearborn-Ohio

Dr. Allen Maurer, a pediatrician from Cincinnati, spoke on "Purpura in Children" at the September 7 meeting of the Dearborn-Ohio County Medical Society.

Elkhart

"Treatment of Acute Renal Failure" was the topic of Dr. Gerald A. Riggs, of the Wayne County General Hospital, Eloise, Mich., when he spoke at the September 7 meeting of the Elkhart County Medical Society.

Floyd

New officers of the Floyd County Medical Society are: Drs. James Y. McCullough, president; William F. Ruoff, vice-president and Daniel H. Cannon, secretary-treasurer.

Grant

The Grant County Medical Society met August 17 to hear Dr. James Wray speak on "Management of Acute Hand Injuries." Dr. Wray is associate professor of orthopedics at the Indiana University Medical Center.

Jefferson-Switzerland

Field Secretary Robert Amick met with members of the Jefferson-Switzerland County Medical Society September 5 and encouraged all members to attend the 1967 annual convention in Indianapolis.

Knox

The Knox County Medical Society has elected the following as its new officers for 1967-68: Drs. B. K. Black, president; C. L. Miller, vice-president; J. S. Murray, secretary and R. J. Jacquemain, treasurer.

Huntington

Dr. Barth E. Wheeler, Huntington is the new president of the Huntington County Medical Society. Dr. Carl S. Ray, Warren, was re-elected secretary.

Marion

The Marion County Medical Society has elected Dr. Dwight Schuster as president and Dr. John O. Butler as secretary. Both of the new officers are from Indianapolis.

Marshall

New officers of the Marshall County Medical Society are: Drs. John K. Guild, Plymouth, president; W. Alfred Kemp, Bourbon, vice-president and M. George Rosero, Culver, secretary-treasurer.

Montgomery

Dr. V. G. Viray is the newly-elected president of the Montgomery County Medical Society.

Newton

Newly elected officers of the Newton County Medical Society are: Drs. John Parker, Goodland, president and Arthur Schoonveld, Brook, secretary-treasurer. ◀

It is bitter irony that the night club dancer earns more than the medical technologist, that the beer salesman is better paid than the chief of nursing, that the Las Vegas blackjack dealer takes home a bigger wage than the physical therapist.

As difficult and perplexing as the hospital cost problem is, there is substantial reason to believe that Americans have unobtrusively adopted a convenient system of double values under which they are cheerfully willing to pay for life's pleasures and patently reluctant to shell out for life itself.

The fog index

Robert Gunning, author of "The Technique of Clear Writing," a good companion to Strunk's "The Elements of Style," has evolved a formula to test clarity of writing.

1. Take any block of words—not less than 100.
2. Figure the average number of words per sentence.
3. Count the number of words with three syllables

or more per 100 words. Add that number to the average number of words per sentence.

4. Multiply by 0.4.

This gives the fog index.

Anything above 14 approaches the danger area—too hard to grasp.

We tested the above block of words and the fog index came to 8.4—*New York State Journal of Medicine*, Dec. 15, 1966.

Association News

EXECUTIVE COMMITTEE

August 12, 1967

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D., G. O. Larson, M.D., Lowell H. Steen, M.D., Lester H. Hoyt, M.D.
Frank B. Ramsey, M.D., editor, *The Journal*; Robert Robinson, attorney, and James A. Waggener, executive secretary.

Membership Report:

Number of members as of	
December 31, 1966	4,409
1967 members as of July 31, 1967:	
Full dues paying	3,851
Residents and interns	4,367
Council remitted	48
Senior	308
Honorary	3
Military	44
Total 1967 members as of	
July 31, 1967	4,356
Number of members as of	
July 31, 1966	4,367
Loss over last year	11
Members delinquent for 1967	68
Number of AMA members as of	
July 31, 1967	4,180
Total 1966 AMA members as of	
July 31, 1966	4,254
Loss over last year	74
1967 AMA members:	
Dues paying	3,676
Exempt, but active	504
	4,180
Number who have paid state dues	
but not AMA dues as of	
July 31, 1967	176
Number who paid state dues but not	
AMA dues as of July 31, 1966	113
1966 AMA members resigned for 1967	35

Headquarters Office

The secretary made a report concerning the OCHAMPUS program.

The secretary asked for clarification concerning the expense items for the Council meeting to be held in Chicago on September 16th. On motion of Drs. Steen and Larson, it was voted the entire expense would be underwritten by the association.

A letter was read from Dr. Corcoran in which he suggested that the wives of those attending the Council meeting be invited to attend all or part of the Council meeting on Sunday. This was approved and Dr. Steen is to make the appropriate arrangements.

Treasurer's Office

The treasurer's report was adopted on motion of Drs. Larson and Steen.

Legislation

National: Mr. Robinson gave a progress report on Federal Planning and the Comprehensive Health Law.

Organization Matters

A letter from Dr. Glen Ryan concerning

the previous action of the committee with respect to proposed changes in the Constitution and Bylaws of the American Association of Medical Assistants was reviewed. On motion of Drs. Rifner and Larson, the secretary was instructed to inform the Indiana Association of Medical Assistants that it was the opinion of the Executive Committee that membership in both the state and national organization should be limited strictly to girls working for physicians or in organizations owned or controlled by physicians.

A notice was read from the Hoosier State Press Association stating the annual dues are increased from \$15 per year to \$25 per year and renewal of membership at the new rate was approved on motion by Drs. Steen and Larson.

An informational letter from the Continental Casualty Company concerning enrollment of several physicians in the Indiana program was reviewed for the information of the committee.

A proposal from Continental Casualty Insurance Company for another Retirement Plan in which they sought the approval of the association was tabled on motion by Drs. Steen and Larson.

A letter from the Methodist Hospital concerning the expansion of some of their activities was reviewed for the information of the committee.

A request of the Indiana Academy of General Practice for the use of the headquarters building for holding a meeting of the GP Club was reviewed. The secretary was instructed to notify the Academy they would like very much to accommodate the group in the building but felt that the anticipated attendance was too much for our present facilities.

A letter from the State Welfare Director to the Department of HEW seeking approval of the omission of the Civil Rights statement on claim forms was read for the information of the committee.

The request of the AMA inviting the association to submit names for possible consideration for membership on various committees and councils of the AMA was reviewed and the committee recommended names to be submitted for these openings.

A letter from Dr. Alcorn concerning the forthcoming seminar to be held September 14th was reviewed for the information of the committee. It was suggested that the chairman of the Commission on Medical Education be invited to attend this meeting.

The secretary of the Building Committee gave a report to the Executive Committee concerning their meeting with officers of the Marion County Medical Society regarding the selling of certain portions of the property owned by the association on Penn-

sylvania Street for construction of a building for the county medical society.

Annual Convention, Indianapolis, October 9, 10, 11 and 12, 1967

A schedule outline for the annual convention was reviewed by the committee.

A letter from AMDOC seeking permission to distribute literature concerning their program was approved and a box to be placed where doctors may obtain this literature.

By consent it was agreed to ask Dr. Reuben A. Solomon to make the response on behalf of the 50-Year Club.

It was recommended that the president reception not be held this year but by consent it was agreed to leave this decision to the president.

On motion of Drs. Steen and Larson \$100 was allocated for prizes for the Annual Golf Tournament. On motion by Dr. Steen and Rifner, \$50 was allocated for prizes for the Trap and Skeet Shoot.

The Journal

"The Forecast of Sales Trends" sent out by the SMJAB was reviewed for the information of the committee.

On motion of Drs. Rifner and Steen, the secretary was instructed to send some information concerning the Industrial Surgical Meeting to the Commission on Public Health.

Medical Defense

A letter from Dr. William B. Adams of Muncie was reviewed for the information of the committee.

Future Meetings

The secretary was instructed to make arrangements for the housing of the committee who will attend the PR Institute in Chicago on August 24 and 25.

International Conference on Abortion Washington, September 8, 1967 was announced and it was agreed that no representative would be sent to this meeting.

Michigan State Meeting in Grand Rapids, week of September 24th—it was felt it would be impossible for anyone to attend this meeting but the president will attend if at all possible.

By consent it was agreed that Dr. Everly would represent the association at the Kentucky State Medical Association meeting.

On motion of Drs. Larson and Steen, Mr. Robinson was authorized to attend a meeting on Comprehensive Health Planning to be held in Chicago on August 16th.

Upon motion of Drs. Rifner and Kintner the president-elect was requested to dra-

a resolution to present to the Executive Committee and Council for submission to the House for providing for the setting of the dates of district meetings. There being no further business, the committee adjourned to meet again at 5:00 p.m. Saturday, September 16th, at the Drake Hotel in Chicago. ◀

THE COUNCIL

July 30, 1967

The Council of the Indiana State Medical Association convened at 9:00 a.m., Sunday, July 30, 1967, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding. Roll call showed the following present:

Councilors:

First District—P. J. V. Corcoran, Evansville, Gilbert M. Wilhelmus, Evansville, alternate
Second District—Joe Dukes, Dugger, Betty Dukes, Dugger, alternate
Third District—Donald M. Kerr, Bedford
Fourth District—Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—Wilbert McIntosh, Riley
Sixth District—Frank H. Green, Rushville, alternate (also AMA delegate)
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie, Paul W. Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting, Herman Wing, Gary, alternate
Eleventh District—James A. Harshman, Kokomo, alternate
Twelfth District—Milton F. Popp, Fort Wayne
Thirteenth District—George B. Gattman, Elkhart, alternate

Officers:

Eugene S. Rifner, Van Buren, president
O. Larson, LaPorte, president-elect
Otis N. Olvey, Indianapolis, treasurer
Ester H. Hoyt, Indianapolis, assistant treasurer

Journal:

Frank B. Ramsey, Indianapolis, editor

Executive Committee:

Alfred V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate
Kenneth O. Neumann, Lafayette, AMA alternate delegate

Maurice E. Glock, Fort Wayne, AMA alternate delegate
Dwight W. Schuster, Indianapolis, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, Indiana University School of Medicine
Robert Yoho, Indianapolis, director, Bureau of Health Education, Records and Statistics, Indiana State Board of Health
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
D. S. Megenhardt, Indianapolis, Professional Advisory Committee, Blue Cross
Glen V. Ryan, Indianapolis, chairman, Blue Shield Board
Richard C. Kilborn, Indianapolis, president, Mutual Medical Insurance, Inc.

Staff:

Robert Robinson, attorney
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

The following were absent:

Councilors:

Fourth District—Robert M. Reid, Columbus
Sixth District—William R. Tindall, Shelbyville
Eleventh District—Lowell J. Hillis, Logansport
Thirteenth District—Otis R. Bowen, Bremen

Alternate Councilors:

Third District—E. L. Wallace, New Albany
Fifth District—A. W. Cavins, Terre Haute
Seventh District—John O. Butler, Indianapolis
Ninth District—Clarence G. Kern, Lebanon
Twelfth District—William R. Clark, Fort Wayne

AMA Delegates:

Eugene F. Senseny, Fort Wayne
Guy A. Owsley, Hartford City

AMA Alternate Delegates:

James H. Gosman, Indianapolis
Robert M. Brown, Marion

Minutes of Council Meeting, June 11, 1967

Dr. Neumann asked that "Blue Cross Board" be changed to "Blue Cross Executive Committee" in his report on Blue Cross at the June 11, 1967, meeting of the Council. **This correction to the minutes was taken by consent.**

On motion of Dr. Popp, seconded by many, minutes of the meeting of June 11, 1967, were approved.

Reports of Councilors

DR. CORCORAN, First District, reported that Dr. Gilbert M. Wilhelmus, Evansville, had been re-elected alternate councilor of the First District.

DR. DONATO, Seventh District, reported that Dr. John O. Butler, Indianapolis, is the new president of the Seventh District Medical Society.

DR. POPP, Twelfth District, reported that Dr. William R. Clark, Fort Wayne, had been elected councilor of the Twelfth District for the term beginning October, 1967, and that Dr. Frederic L. Schoen, Fort Wayne, was elected alternate councilor.

DR. GATTMAN, Thirteenth District, extended an invitation to the councilors and officers to the Thirteenth District Society meeting to be held in South Bend on September 13, 1967.

Matters from Council Committees

1. Council Liaison Committee with Blue Shield.

a. *Payment of Fees for Welfare Recipients under Part B of Title XVIII, PL 89-97.* Dr. Kerr, chairman of the Council Liaison Committee with Blue Shield, reported that the Blue Shield Board had met on Sunday, July 23, 1967, at which time the board considered the Council's request that Blue Shield make payment in one check for the care of welfare patients to those physicians who chose Option B. The physician, in turn, would supply Blue Shield within ten days an itemized statement marked, "Paid in Full."

"The attorneys from the Health, Education and Welfare Department have rejected the check, so this will not be. There is instead a system which apparently will be approved involving a card. I would point out that as of this date, there are only about 12 to 14 doctors who want to participate in the care of welfare patients on this basis, as compared to some 1,300 who have chosen the first option.

"They will be given a card which will be signed by the patient. They will submit their charge and the statement of the services rendered on the 1490 form. The patient will sign this card which says, in essence, 'I agree to have the funds paid directly to this doctor which would ordinarily come to me.' It seems that this is about the best that will be arranged from this. It eliminates the paper work in regard to the statement that previously had to be filed.

"As of now, the system of their option B will be that those doctors employing it will be sent cards, the patient will sign it, he

will send the card with his 1490 form and will be paid in full, if this is possible. If it is not possible, he still has the right to appeal for his charges. Mr. Kilborn cannot pay unless it is a paid-in-full type of arrangement. This is necessary, the attorneys say, so that Blue Shield can be reimbursed for the expenditure of Blue Shield funds in the care of welfare patients."

On motion of Dr. Kerr, seconded by many, the Council approved the procedure as outlined above by Dr. Kerr wherein a card signed by the patient, plus a statement of services rendered, to be submitted on Form 1490, will be used.

Dr. Kerr stated that Blue Shield had asked that he point out to the Council that if this system of handling this business is widely used, Blue Shield will not be able to honor it because of administrative costs, and it therefore will not be publicized.

b. Relationship between Blue Shield and the Indiana State Medical Association. Dr. Kerr read two letters, one which he had written to Dr. Glen Ryan, chairman of the Blue Shield Board, and Dr. Ryan's reply, concerning the relationship between Blue Shield and the Indiana State Medical Association.

Dr. Kerr moved that the Council approve sending these two letters to all members of the association in a direct mail. Motion seconded by Dr. Olvey.

Dr. Donato suggested that the letters be sent only to those inquiring or complaining about this matter.

Dr. Taylor moved to amend Dr. Kerr's motion to the effect that these letters be sent to the constituent county medical societies rather than the entire membership of ISMA. Motion seconded by Dr. Popp. Amendment accepted by Dr. Kerr. Motion put to vote, and carried.

On voting, Dr. Kerr's motion as amended was adopted by the Council.

c. Form to Be Sent to Union Members. At the July 23rd Blue Shield Board meeting, the board approved a form to be sent to union members when the allowance is less than the charge made by the physician.

DR. SHIELDS: The statement on this form seems to us to place the physicians of our association in the position of being unreasonable, when the allowance made by Blue Shield is less than that billed by the physician. We do not have the exact final wording, but the statement as originally presented said "The Blue Shield allowance is the maximum payment available in accordance with a statistical determination of the usual and customary charge in the

area where the service was performed." We believe we should object to any statement which places any of our members in a bad light with their patients, and therefore we recommend for your consideration a statement as follows:

"Our allowance does not necessarily reflect your physician's usual and customary charge or charges for his services, but does reflect our average allowance for the procedure or procedures performed."

This was discussed by Drs. Petrich, Steen and Mr. Robinson, following which, **on motion of Drs. Petrich, Shields and Taylor, the Council voted "that there should be no comment on this fact sheet, that it be presented to the individual insured as a fact sheet for payment allowances under the Blue Shield program."**

MR. RICHARD C. KILBORN, president, Mutual Medical Insurance, Inc., later in the meeting, reported that he had consulted the Council Liaison Committee on Blue Shield on July 29 and the Blue Shield Board on July 23 for advice concerning the statement on the fact sheet.

"On Medicare, with every check that goes out there is attached an explanation of what we paid, what we didn't pay, and why we didn't. . . . The General Motors Corporation, Ford, Chrysler and the unions, the UAW particularly, have a strong feeling that we have a responsibility to explain our payments when we do not pay our bill in full. . . . Our preference is to do just as we do now, to send out a check. Obviously this is the simplest thing for us, but the unions and companies point out that they end up quite often in grievance committee meetings, or grievance situations which are expensive for both the corporation and the union; they say ultimately we still have the responsibility of explaining our payment. And this we cannot deny. It was on this basis that we came up with this prospective language."

DR. STEEN explained the Council's position. "This was discussed both in the Executive Committee and at length in the liaison committee, and on the floor of the Council. It is the feeling of the councilors that the verbiage indicated was not only unacceptable but tended to infer that the responsibility for charging more than your payment was the fault of the doctor. It was therefore the unanimous vote of the Council that no verbiage be put on at all, that you follow the procedure now used by some of the commercial carriers and steel companies at which time they send out a list similar to the one you have made

on which it is listed what the charges were by the various organizations and individual who assessed charges and in the next column what the company paid, totaling both up indicating what balance there was for the indemnification of the member. We felt that this was probably the best way to do this since we were informed by legal counsel that the verbiage, that any of the verbiage, compromise and original that we came up with might be subject to a libelous action on the part of a physician who took exception to this at a later date, and there is a case at law to substantiate the fact that these findings have been upheld in the past in courts of law."

MR. KILBORN: The language that I am referring to would go out with an individual check. Your suggestion would not be pertinent to ours because we are sending out one check to cover one given service with the doctor's name on it; it is not a multiple listing. The language that I would suggest that might be more acceptable to the Council and might be acceptable to the corporations, if the Council would consider it, is: **"The Blue Shield allowance is the current maximum available under our local county program. However, the physician always has a right to contract charges different than our allowance."**

On motion of Drs. Kerr and Corcoran, the Council voted to reconsider the matter of the Blue Shield explanatory difference."

Discussed by Dr. Shields and Rifner and Mr. Kilborn.

Dr. Larson read the statement which was recommended by the Executive Committee earlier in the Council meeting:

"Our allowance does not necessarily reflect your physician's usual and customary charge or charges for his services, but does reflect our average allowance for the procedure or procedures performed."

Mr. Kilborn then reread the above statement which he had presented.

DR. TAYLOR: I think you are losing sight of the point here. If we acknowledge anything regardless of what the semantics are, then we are acknowledging that we have to defend our position. And I don't think we ever have to defend our position in this. Indiana Blue Shield was never meant to be a service plan except for the limited implications under Resolution 2. We have never agreed to any type of fee schedule and I don't think we should start. If we approve any verbiage here, regardless of whether we write it ourselves or they write it, then I think labor and management

ement have achieved what they want to achieve and that is to get an expression of acknowledgment from the physician that he is responsible for this overcharge and not the contract that they have written with Blue Shield. I don't believe that Blue Shield should approve anything here. If Blue Shield wants to offer an explanation, then it is their business to do so, but don't let them come to us and ask for an explanation, or approval. If they do it, they do it on their own. They sold the contract to the doctors.

MR. KILBORN: That's a real good point. I originally did not intend to ask for the Council's permission *per se*. We've been accused of very poor communications and merely I attempted first of all to tell the board and got the approval at the board level. Then I merely reported to the liaison committee the language that the board had approved. I don't really specifically seek an approval from the Council. I don't think I need to point to any doctor and say this is what was approved by the Council. I think of this as a way of communicating to the Council. I have had this request from management and this is the best language that we have come up with — at least the Blue Shield Board has approved it and the liaison committees yesterday tentatively said this would not be a big problem for them. Now, that was the way of a report.

Discussed further by Dr. Corcoran, Mr. Robinson, Drs. Shields and Rifner.

DR. RIFNER: I wonder if it is necessary to have any statement other than the fact that this is what Blue Shield pays and this is what the doctor charged. I wonder if union and management really want an explanation as to why there's a difference, or if all they want to do is to show that there is one.

MR. KILBORN: The reason I brought the matter up to my board was because obviously what you're suggesting we do, we have been doing. We haven't sent out a statement saying the doctor charged so much and our payment is so much, because we send a check which shows what our payment is. . . . We do have a specific request from the companies and unions asking us for an explanation when we don't pay the full bill. . . . So far we have kept General Motors because of Resolution 26, and solely for that reason. And that is due to the state medical association. We are interested in this business, it is important to us, in our thinking. And that is why it came to the Council, not specifically for

approval, because I can appreciate the fact that the legal counsel points out. I don't think the association should get itself in a spot where it approves or disapproves what we pay verbatim, nor our language in our letters verbatim, because this is obviously our legal responsibility. If there are any suits involved, they should be against Blue Shield with no counter parties, especially the state medical association.

Dr. Taylor moved that the Council reaffirm the position it had taken earlier in the meeting wherein the Council voted "that there should be no comment on this fact sheet, that it be presented to the individual insured as a fact sheet for payment allowances under the Blue Shield program." Motion seconded by Dr. Shields, put to vote, and carried unanimously.

d. *Realignment of Definitions of "Usual" and "Customary," "Prevailing" and "Reasonable."* The chairman called upon Dr. Everly, chairman of the Executive Committee, to discuss this subject.

DR. EVERLY: Mr. Chairman, the Executive Committee has had called to its attention the new arrangement between the national Blue Shield and the steel industry for coverage of steel workers. We were notified of the meeting being called by the AMA for Monday, July 24, to discuss this new arrangement; however that meeting was cancelled. Also, our officers received an urgent request to meet with other officers in Ohio, on Sunday, July 16, to organize an effort to object to the conditions of this particular agreement. The basis of this objection was the use of the word "prevailing" throughout the entire agreement. As you are aware, our House of Delegates has insisted on the term "usual" and "customary." Our delegates to the AMA carried on an intensive floor fight to remove the term "prevailing" and use instead the words "usual" and "customary." I would request, Mr. Chairman, that our legal counsel explain to the Council the meaning of "prevailing" and the words "usual" and "customary," and following his explanation that the Council adopt a policy statement to the effect that "prevailing fees" is synonymous with the term "usual and customary" and furthermore, that these terms are to be interpreted to mean "as they relate to the individual physician and not to the community."

Dr. Steen then read from the minutes of the October, 1965, meetings of the House of Delegates:

"We recommend that physicians inform all third parties that effective 1 January, 1966, physicians will participate only on the basis they receive their usual and cus-

tomary fee for like services as paid for by the private paying patients; and it is further recommended that the usual and customary fees be defined as follows:

USUAL: The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patients, (i.e., his own usual fee.)

CUSTOMARY: A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area. (Socio-economic area of a metropolitan area or socio-economic area of a county.)

Now I read to you from the Council minutes of April 16, 1966:

"It is the official policy of this association that every physician bill and receive for his professional medical services, his usual, customary and reasonable fee. 'Usual and customary and reasonable fee' is defined as follows:

USUAL: The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patients, (i.e., his own usual fee)."

No change.

"CUSTOMARY: A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area."

No change. Now, then we then went one step further and defined 'reasonable.'

REASONABLE: A fee is 'reasonable' when it meets the usual and customary criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

In other words we define reasonable as identical with usual and customary. Now, we shall hear from Mr. Robinson.

MR. ROBINSON: You will note in your definition of "usual" and "customary" the definition of "usual" would say that it's the usual fee of the physician. However, "customary" is defined as the customary fee in the area. And of course this then gets into "prevailing" fee and this is what you are seeking to avoid. And, based upon some court decisions and definitions, the term "usual and customary" of itself being ambiguous, I suggest that you now clarify this to mean what I understand you to mean and that is the fee of the physician, not a prevailing fee or an average for the area. Therefore I suggest the following:

The term "usual and customary fee" shall mean and shall be defined and

used as the "usual and customary fee" of the physician. The term "prevailing fee" shall mean and shall be defined and used as the prevailing fee of the physician.

The term "reasonable fee" shall mean and shall be defined and used as the reasonable fee of the physician. The use of any other term similar to or in place of "usual and customary fee," "prevailing fee," or "reasonable fee" shall mean and shall be defined as the fee of the physician.

I think by considering this you will clarify what you are intending.

On motion of Drs. Popp and Harshman, the Council voted to rescind the action taken at the April 16, 1966, Council meeting in approving the above definitions of "usual and customary" and "reasonable."

Discussed by Drs. Shields and Taylor.

Dr. Popp moved that the Council accept Mr. Robinson's definition as the Council policy and that it be forwarded to the ISMA House of Delegates with the Council's recommendation that the House approve it. Motion seconded by many, put to vote, and carried.

2. Council Liaison Committee with Blue Cross.

a. Blue Cross Contract with Mental Health Clinics. Dr. Rifner spoke against the Blue Cross contract with mental health clinics whereby Blue Cross, instead of Blue Shield, pays for the professional services in these clinics, which is a variation from association policy.

This was discussed by Drs. Rifner, Taylor, Kerr, Neumann and Harshman.

Dr. Taylor read from his report to the Council on January 22, 1967, as follows:

"I believe that the Council should object to Blue Cross for writing a contract to cover professional fees in these clinics and should also direct a letter to the Indiana Neuropsychiatric Association outlining the ISMA position on this matter and requesting their cooperation.

"Mr. Chairman, I move the acceptance of this report."

(Excerpt from minutes, January 22, 1967, Council Meeting:

"Dr. Taylor's motion was seconded by Dr. Petrich, discussed by Dr. Neumann, put to vote, and carried.

"The secretary was instructed to write a letter to the Indiana Neuropsychiatric Association, and to protest to Blue Cross, as outlined in Dr. Taylor's report."

On motion of Drs. Taylor and Popp, the motion made by Dr. Taylor at the January 22, 1967, meeting of the

Council was amended to include that a letter be written to the ISMA Section on Nervous and Mental Diseases as well as to the Indiana Neuropsychiatric Association. The motion made at the January 22, 1967, meeting would then read:

"The secretary was instructed to write a letter to the Indiana Neuropsychiatric Association and to the ISMA Section on Nervous and Mental Diseases, and to protest to Blue Cross, as outlined in Dr. Taylor's report."

b. Blue Cross Professional Advisory Committee. Dr. Dennis Megenhardt, Blue Cross Professional Advisory Committee, commented that liaison between the ISMA and Blue Cross had been extremely strong during the past year. "I don't know of any time when we have had better relationships with the medical association and this, we hope, continues."

Dr. Megenhardt asked that the Council first hear from Dr. Taylor and then from Dr. Neumann, **and this was taken by consent.**

c. Council Liaison Committee with Blue Cross. DR. TAYLOR, Council Liaison Committee with Blue Cross, presented the following report:

The first portion of my report concerns the matter referred to your committee by the Council at its meeting on June 11, 1967 (Agenda Item K-2). In order to understand this Blue Cross proposal, I want to review the events that occurred within Blue Cross as the proposal developed. I shall do this by direct quotations from the Blue Cross Board and Executive Committee minutes and my recollections of verbal discussions at meetings of the Blue Cross Medical Advisory Committee meetings.

At the meeting of the Blue Cross Executive Committee on May 25, 1967 the following was presented:

"Mr. Spring then presented a proposal for Blue Cross to provide coverage for pre-admission testing for surgical patients as follows:

This Blue Cross Plan proposes to provide hospital outpatient tests and examinations as benefits for surgical patients when pre-operative diagnosis has been established, and

- 1) Surgical procedures are scheduled and room reservations confirmed.
- 2) Tests and examinations are those which normally are a part of required care ordered by the responsible surgeon (physician).
- 3) The outpatient tests and examinations are intended to eliminate one or more days of inpatient care prior to scheduled surgery.

- 4) The fact of having the tests and examinations as an outpatient will not, in the judgment of the surgeon (physician), endanger the patient.

- 5) The results of the tests and examinations will be made a part of the patient's record at the time of admission.

"It is recommended that each participating hospital adopt the following procedures:

- 1) Surgeon schedules surgery and make room reservation.
- 2) Surgeon orders needed tests and examinations.
- 3) Patient reports to a specific location within the hospital sufficiently in advance of admission date to assure the preparation of a record of tests and examination results to be (a) reported to the surgeon prior to admission, and (b) made a part of the patient chart at time of admission.
- 4) Charges for such tests and examinations become a part of the bill. Blue Cross for inpatient care according to the benefits of the Blue Cross Certificate held by the member.

Comments—It is not intended that Blue Cross shall pay when:

- 1) Tests and examinations are for research, case finding or surveys."

Mr. Spring explained that this document was prepared to cover the important points in such a program and that a complete procedure, including the effective date, would be prepared and presented to the Executive Committee at its next meeting. He said that this proposal would be submitted to the board of the Indiana Hospital Association and to the Council of the Indiana State Medical Association for endorsement, since the cooperation of both the hospitals and physicians would be required to make it work efficiently and effect the economies that might be expected to result from it.

After discussion, the proposal was approved, and Mr. Spring was directed to secure endorsement of the program by the Indiana Hospital Association and the Indiana State Medical Association.

The Blue Cross Executive Committee minutes of June 15, 1967 includes the following:

"Mr. Herod stated it had been suggested that the meeting of the Executive Committee held on May 25, 1967 be directed to include the following in the discussion regarding the proposal for Blue Cross to provide coverage for pre-admission testing for surgical patients:

Dr. Neumann asked if this would include the use of x-ray film transferred from a local clinic to the hospital. Mr. Spring stated that Blue Cross would like to get it working in the hospitals first, and then explore

ther possibilities, including this, as a money-saving practice."

The correction was accepted.

The following appears in the minutes of the Blue Cross Board of Directors on July 3, 1967:

"Mr. Spring said that he was not present at the June 15 meeting and, therefore, he would like the board to approve a further revision because the statement referred to x-rays only and should have included laboratory services as well. He said he had written to Dr. Neumann regarding the statement and received the following letter from Dr. Neumann, which he believed clarified the whole matter:

"In order to clarify the minutes of the Executive Committee of May 25th and to firmly establish the full intent of our discussion, I would propose that the minutes be amended as follows:

Dr. Neumann asked if this would include the use of x-ray films or reports and laboratory findings transferred from clinics or approved laboratories to the hospital. I believe in our discussion we had included both x-ray and laboratory studies and although local clinics were mentioned, I do not believe it was the understanding that it be limited to 'local' clinics. I believe that we had discussed the fact that such pre-admission studies would necessarily have to be made in x-ray or clinical laboratories that met certain qualifications in order to make a part of the clinical hospital record. I believe it was the understanding that Blue Cross and Blue Shield would pay these charges in the customary manner as is now being done; if this proposal were adopted.

Certainly anything that we can do, either physicians or hospitals, to decrease the length of stay or the cost is of the utmost importance in view of the increasing criticism of hospital costs."

A lengthy discussion followed. Mr. Spring said that the proposal had been approved by this board and the Indiana Hospital Association, and that hopefully, it would be approved by the Council of the Indiana State Medical Association. It had been discussed with Mr. Kilborn of the Blue Shield plan, and that it would be presented at the meeting of the Blue Shield Board of Directors on July 23, 1967. He further stated that the proposal had been discussed and approved by the Department of Insurance.

This proposal was discussed in depth at the Blue Cross Medical Advisory Committee meetings on July 13th and July 20th. No minutes of these meetings are available but the discussion as I remember it centered around these points:

- 1) That pre-testing be limited to patients scheduled for elective surgery and within a reasonable time (i.e., 72 hours) prior to admission.
- 2) That the pre-testing, which involves primarily professional services (radiology and pathology), may be obtained from any qualified radiologist or pathologist of the patient's choice and that his reports will be accepted by the admitting hospital.
- 3) That since these are professional rather than hospital services, that payment for these services be transferred from Blue Cross to Blue Shield as soon as possible.
- 4) That Blue Cross use its influence to change the policy of certain Indiana hospitals requiring that a patient be admitted to the hospital before the patient can be placed on the surgical schedule.

No one can deny that we should explore every possibility to keep down the cost of medical and hospital care and on the surface, this proposal would appear to do this. However, if we approve this proposal as initially outlined by Mr. Spring, we would be accepting the principle that Blue Cross can extend its coverage to outpatient professional services on the one hand, while on the other, we sue Blue Cross to give up the coverage of inpatient professional services.

Apparently this proposal offers some hope of decreasing or at least forestalling, to some extent, rising hospital costs which Blue Cross must meet, so that the proposal is of economic worth to Blue Cross. Obviously Blue Cross feels that our support is necessary, or at least desirable, or they would not have sought it. I also believe that it is obvious that Blue Cross wants to crack the whip on several hospital administrators whose admission rules regarding elective surgery run up the cost of hospital care.

We may have found ourselves in a worthwhile bargaining position on this whole matter. First of all from the dollar and cents standpoint, the cost would be the same whether the pre-testing were paid for by Blue Cross or Blue Shield so that any savings would still be affected, but from our standpoint it is paramount that in some manner our principle that all professional services (which the pre-testing is) should be covered by Blue Shield. This proposal may be the mechanism whereby we can get Blue Cross to admit to this principle.

I would recommend that we approve the pre-testing proposal made by Blue Cross contingent upon their acceptance of the four (4) points that were discussed at the

Blue Cross Medical Advisory Committee and which I previously listed.

I understand that the Blue Shield Board on July 23 did not approve this proposal, however, I believe that they might reconsider their position if they know that they could work around the four points I have listed above. This is my personal opinion.

Mr. Chairman, I move the Council approve this portion of the committee report.

Dr. Taylor's motion for acceptance of this portion of his report was duly seconded, put to vote, and carried.

THE CHAIRMAN, upon behalf of the Council, thanked Dr. Taylor for the very hard work he had done and for the excellence of his report.

THE CHAIRMAN read from the Council minutes of June 12, 1966:

"The Executive Committee recommends to the Council the introduction of the following resolution at the House of Delegates in October:

"Upon motion duly made and seconded, the Council accepted this resolution, which reads as follows:

"WHEREAS, several insurance companies require inpatient status in order to cover diagnosis and other services, and

"WHEREAS, such requirement utilizes hospital beds unnecessarily since many such services can be done on an outpatient basis,

"NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association strongly recommends to the insurance carriers in the state that the inpatient status requirement be discontinued for these services in order to free as many hospital beds as possible so they may be utilized by patients with a definite medical need."

This was introduced by the Council to the House of Delegates in October, 1966, as Resolution No. 23. Dr. Scamahorn, chairman of the Reference Committee on Insurance, presented the following report:

"Resolution No. 23—HEALTH INSURANCE. Mr. President, the committee approves Resolution No. 23, and recommends its adoption, and I so move."

(Motion seconded, put to vote, and carried.)

The question was asked, "If perchance, on an outpatient basis, a patient is worked up and if that patient does not enter the hospital and does not have an operation, what happens then?"

The matter of collecting for outpatient services for elective surgery was discussed by the chairman and Drs. Popp, Taylor and Harshman and it was pointed out that the report says "previously diagnosed",

so this eliminates the so-called workup.

The chairman asked Dr. Taylor to take this subject up with the Blue Cross-Blue Shield representative liaison committee chairman, to make sure that no misunderstanding exists.

Dr. Neumann announced that Dr. Taylor had covered the subject so well that he had no further comments.

DR. MEGENHARDT: Dr. Taylor, I, too, want to thank you for presenting this so well, and I am with you 100% on acceptance of this and I feel, like you, that Blue Shield might reconsider this once they know the whole background of this problem. I think it will be a real help in keeping down the cost of medical care on many, many patients. Thank you.

Dr. Taylor continued with his report of the Council Liaison Committee with Blue Cross:

Mr. Chairman, I move that the president be requested to write Mr. Spring informing him of the action of the Council.

At the meeting of the Blue Cross Board of Directors on July 13, 1967, the format for a contract between Blue Cross and Indiana Nursing Homes was presented for approval. Article 3, paragraph 3 reads as follows:

"3) Blue Cross shall initially acknowledge the admission for a period not to exceed 30 days. The initial acknowledgement can be extended in multiples of 30 days upon the receipt by Blue Cross of an Extended Stay Care Information Form signed by the attending physician and attesting to the further medical need of the institution's services."

It is the policy of this association by action of the House of Delegates that we do not accept the principle of certification for initial or continuing hospital care and I feel sure that the resolution passed is broad enough to cover nursing home care.

Your committee recommends that Blue Cross and the Indiana Nursing Home organization be notified that the Indiana State Medical Association does not acknowledge or accept this stipulation. The committee also recommends that the membership of the association be so advised in the next newsletter or an early issue of *The Journal*.

Mr. Chairman, I move the Council approve this portion of the committee report.

Dr. Taylor's motion was seconded by many, discussed by Drs. Kerr and Rifner, put to vote, and carried.

Reports of Guests

DR. GLENN W. IRWIN, JR., Dean, Indiana University School of Medicine: Mr.

Chairman, members of the Council, I have only a brief report for you today. Most of you, I am sure, are aware that Governor Branigin recently appointed three members to the Board of Medical Education. These members include Dr. Joe Black, representing the Indiana State Medical Association, Dr. Jack Hall, representing the Directors of Medical Education, and Mr. Richard Trenkner, representing the Indiana Hospital Administrators.

This Medical Education Board will meet for the first time on July 31, 1967, to proceed with implementing the statewide plan. This board is charged primarily with the matter of partial payment of intern and resident salaries throughout the state as well as certain postgraduate and continuing medical education programs in the hospitals of the state.

Dr. George Lukemeyer, associate dean, and I have discussed with several groups throughout the state the part that Indiana University itself will play in this plan. We have had a considerable number of negotiations from the standpoint of statewide faculty, subsidizing directors of medical education, and others as it applies to various communities. Plans for implementing this medical program are well along in Indianapolis, South Bend, Fort Wayne, Evansville, Muncie and Lake County.

You will be interested to know that the telecommunications network is under construction. It is now possible to have one or two-way television communication from the medical center to Bloomington, Indianapolis, Lafayette, Fort Wayne and Lake County. Connections to hospitals within these cities are being planned and constructed so that hopefully, we will soon have live programs in these communities and their hospitals.

The Indiana General Assembly of 1967 appropriated money for a telecommunications system for the four state universities and their regional campuses, and hopefully, during 1968 essentially all of the state of Indiana will be covered by this system.

The medical school faculty finally, after two and a half years of struggle, has approved a major change in the curriculum. The major change that the practicing physicians will note is an increase in the number of elective courses that can be taken throughout the state beginning this fall. These new courses and programs will be created carefully; however, in one year I predict that many medical students will be taking clinical elective work throughout Indiana. Most medical students and faculty members are enthusiastic about this Indiana plan.

We have a short time in which to make this statewide plan work, but we have a golden opportunity to do something medi-

cally unique in Indiana. The school of medicine and this association, I think, can make it work. Thank you, Mr. President.

DR. GLEN V. RYAN, chairman, Board of Directors, Mutual Medical Insurance Inc., spoke briefly on three points: (1) the welfare program, (2) regular Blue Shield business, and (3) Medicare business. He reported that the welfare contract now had gone through the statehouse, had been properly signed, and had been put on file. "To date, 1,275 physicians have accepted alternative No. 1, as outlined in Dr. Rifner's letter, while only 18 have accepted alternative No. 2.

"General Motors, Ford, and Chrysler are still in negotiations with Blue Shield. . . . As far as Blue Shield is concerned, the new benefits for U. S. Steel go into effect August 1, and I understand that certain representatives of Blue Shield have met with the Lake County Medical Society on several occasions and have promised the county their full cooperation, and also, the county has agreed to help Blue Shield make the steel program work.

"In regard to Medicare, during the first year from July 1, 1966 to July 1, 1967, Medicare paid out \$9,900,000.00 plus, and it is estimated by the Social Security Administration that for the next contract year, from July, 1967 to July, 1968, it will be \$16,000,000.00. . . . The average processing time of claims has been cut down from 28 days to 14 working days and about 70% of our claims are now paid in 10 working days or less.

"We do want to comment that the liaison committees of the two organizations have had more meetings in the past two months than we have had in the past two years. . . . The most recent one was yesterday afternoon, and I think with this kind of cooperation, things will go more smoothly than they have in the past."

Dr. Everly, at the request of the chairman of the Council, read the following statement:

"The Executive Committee would like to call to your attention the minutes of the Blue Cross-Blue Shield Labor Advisory Committee meeting of June 1, 1967. In the remarks made before this group by Mr. Kilborn, he stated, 'In discussing Medicare our records indicate that 67% of all doctors are now taking assignments on all cases received.'"

The chairman called attention to the last report when the figure was 37 or 39%, and Dr. Ryan was asked to clarify this statistic for the Council with Mr. Kilborn, and to ask Mr. Kilborn to confirm or deny this figure of 67%.

Dr. Ryan's report was discussed by Drs. Taylor, Dukes, Shields and McIntosh.

DR. ROBERT YOHO, director, Bureau Health Education, Indiana State Board of Health, representing Dr. A. C. Offutt, State Health Commissioner, spoke on PL 89-749, the law under which the State Board of Health has been named by Governor Branigin as the State Health Planning Agency and Dr. Offutt as the planning officer.

"The one section within this bill which concerns us at the moment is 314(a). This provides for comprehensive health planning. The law has been in effect since January 1, 1967, but the appropriations for planning were made only three or four weeks ago. The agency will plan for the total health program in Indiana. Indiana's share of planning funds is \$97,000.00 a year.

"Section 314(b) repeals the areawide planning provision under the Hill-Burton bill and places it under the comprehensive planning, and in the future any request for planning of areawide medical facilities made by an agency in a given state must be approved by the state planning agency, which, in this instance, is the State Board of Health.

"Section 314(a) also provides that there shall be a State Planning Council, to which representatives of the various health professions shall be appointed, with appropriate geographical distribution. Also on this council will be representatives of the users of health services. The law requires this latter group be in the majority. At the moment we are thinking of a council of from 25 to 30 members. It may be necessary to increase this number to get complete representation of interests."

Dr. Yoho reported that Dr. Offutt had asked representatives from the following organizations to meet with him on August 1, as a steering committee to advise him on the membership of this council: Indiana State Medical Association, Department of Public Welfare, Rose Polytechnic Institute (Mr. Logan, president, an engineer and an expert in systems planning), Indiana Hospital Association, Indiana State Chamber of Commerce, Department of Mental Health and from labor.

Dr. Yoho also spoke of certain planning that has occurred through federal support and other planning that is now in progress:

- 1) The mental health plan developed two or three years ago through a federal grant;
- 2) Areawide planning for medical facilities, directed primarily toward hospital and nursing home planning;
- 3) The grant for planning in the field of vocational rehabilitation. The governor asked the State Board of Health

to direct this planning.

"We have just now received our grant and are trying to find the personnel to implement the program."

- (4) Regional planning for heart, cancer and stroke, which is being done under the sponsorship of the Indiana University School of Medicine and in which the State Board of Health and other groups are deeply involved.

"It is extremely important that this comprehensive health planning be done well, because we feel that the activities that are supported by the federal government in the future, after such a plan is completed, will have to be projects that help implement the comprehensive health plan or blueprint.

"Representation on this health planning council, which is required by law and which in a sense is an advisory policy-making body is significant. And I think it is obvious that the state medical association should be well represented on this council.

"In addition to representation on that council, and your influence on planning, Dr. Offutt feels that the medical association, through its individual membership and through its policy-making bodies, has certain information and knowledge, and can render certain services to the State Board of Health. And these services are not available from any other source. The advice and opinion, based upon the knowledge which the individual physician has, and which the group has as a profession, is most important to successful planning of public health in Indiana, and the simplest way for us to be sure that we get this advice, this counsel and assistance is to contract with the state medical association. Such a contract has two parts, (1) the State Board of Health will pay a certain amount of money in return for this service and assistance from the state medical association. We have included in our request for the planning funds money for contractual services, and (2) Each year by July 1, we have to submit a plan to the U. S. Public Health Service for funds with which we operate a portion of the program of the State Board of Health. This is our regular on-going program."

Dr. Yoho also spoke of the National Highway Safety Program which the governor's office is in the process of developing and which will be partially funded by the federal government. "There are 16 functional program areas in which the federal government has developed standards. In order to qualify for the funds, Indiana has to develop a program in 16 functional program areas, such as driver education, uniform traffic signals, highway construction, driver licensing, automobile

inspection, courts, law enforcement, etc.

"Also, the governor has assigned to the State Board of Health the responsibility for the development of a program in emergency medical care of highway accidents and alcohol and highway accidents. We would hope that the emergency medical care area will be a joint effort between the State Board of Health and the medical profession. The state police also have a contribution to make in this area. We will be calling on you for advice and counsel concerning this important program.

DR. DONATO, chairman of the Council Committee for the Study and Implementation of Governmental Medical Programs, recommended that the information brought to the Council by Dr. Yoho be made a part of the minutes of this Council meeting, and this was accepted by consent.

Dr. Donato announced that with the help of Mr. Robinson, his committee hoped to be able to have an analysis of PL 89-749 and to give the membership a positive program within the next 30 days. "I think all these health commissions and these users, or facilities, have to be alerted to the fact that nothing can be done unless the doctors cooperate. And we are going to try to keep them informed of that fact."

Dr. Donato read the following paragraph from PL 89-749, **which he asked also be read into the minutes:**

"This law establishes a plan process to effect statewide health plans which will or should identify health problems in the state, said health objectives toward improving availability of health services, identify existing resources and resources needs, relate the activities of other planning and health programs, provide assistance to state and local officials, private voluntary health organizations and institutions and to other programs supported by grants, and effect allocation of resources to accomplish the planned objective."

Reports of Officers

DR. EUGENE S. RIFNER, President: Mr. Chairman, I would first like to deviate from what I have written here to say that the reports given by Dr. Taylor and Dr. Kerr to my knowledge, since I have been on the Council, have never been superseded. I won't say they haven't been equalled, but I can't remember their equal. In detail and in fact, presenting here exactly what was going on and I think these men are to be commended for their work on the Council.

Immediately following our meeting in April, the Executive Committee and two members of the Commission on Legislative Activity proceeded to Washington, D. C. There we conducted the annual pilgrimage

of the ISMA to the members of the House of Representatives and to the Senators from Indiana. We visited all of them in their offices and entertained them in the Washington Press Club on Monday evening. I feel that we found a group of Congressmen much more respectful of the ideas and policies of the Indiana State Medical Association than we had found in prior years.

On April 19th and 20th, your president and Mrs. Rifner attended the Woman's Auxiliary where the president urged auxiliary members to read the *Indiana State Medical Journal* and report to their husbands. I felt that these women could bring more husbands into the fold of knowledgeable physicians. Dr. and Mrs. Larson and Dr. Steen and Mr. Waggener also attended.

On April 22nd and 23rd, I attended the Blue Shield seminar in Indianapolis. My impressions of that meeting appear in the May issue of *The Journal*.

On April 29th, I attended and spoke at the Indiana Association of Medical Assistants. This is a group that is growing and I feel should receive more attention from the Indiana State Medical Association than it has in the past.

On May 3, I attended the Tuberculosis Association annual meeting, and thanked that organization for its good work. This was done in the afternoon. In the evening I attended the Indiana Academy of General Practice annual banquet to see my friend and fellow Grant County physician Lester Renbarger installed as president-elect of that organization.

On May 8, 9, 10 and 11, I attended the Wisconsin State Annual Convention. Here I listened to reference committees and their House of Delegates. I was royally cared for by one of their past-presidents while there. Their problems and their solutions seem very similar to ours.

On May 15, 16, and 17, I attended the Ohio State Medical Association annual meeting with much the same results. I did note that the Ohio Council had a formal dinner limited to the Council members, their wives, the officers and their wives. This is a formal affair where no business is conducted. It was a very delightful thing, they panned one another but did not conduct any business or talk about any of their problems, just had a nice get-together where everybody got to know each other. The rest of the members of the convention were not there. It was just their Council, officers and their guests. I felt it might be worthwhile for this organization to think about that during the next convention.

On June the 2nd, 3rd, and 4th, I attended the annual AMPAC meeting. This was a workshop and I feel after last night

that our board is beginning to execute some of the ideas that we learned there.

On June 10 and 11, I attended the meeting here prior to the AMA, the same as you.

On June 16 through June 23, I attended the Atlantic City AMA Convention. I feel that our delegation was true to the dictates of the Council in helping elect Dr. Annis, and the passage of our resolution. The resolution was changed in the reference committee, but our delegates were able to return it to its original form on the floor of the House. This of course will be reported in more detail by the delegates.

July was not a very active month. Thus between Blue Cross, Blue Shield and one or two other meetings, I returned to the garden spot of Indiana to practice medicine.

I wish those here who foolishly or unwisely have aspired to this office would note the pace of the president. The president's page has very few readers, judging

from the mail. Apathy reigns supreme among Indiana physicians. I cannot help but be amazed at the quiet surrendering attitude of the Indiana physicians at the passage of Medicare. What kind of sweet kiss or what kind of stinging slap will it take to awaken this Prince Charming or this Rip Van Winkle? I fear that he will awaken too late some morning to read in the *Indianapolis Star* that for all procedures have been set by the federal government and that his beloved Indiana Medical Association, Blue Shield and Blue Cross have been disbanded by court order for they are no longer needed. And all the while, they will have slept the bed of complacency lulled by the music of prosperity. That's a dull and nasty way to end a report, but it seems to me that apathy is our biggest problem. I've even felt that we should do something quite nasty or something directly opposite to policy in order to awaken them so at least they'd come up here and talk about it. Thank you.

DR. OTTIS N. OLVEY, treasurer, presented the following report on the financial status of the association as of June 30, 1967, which, on motion of Drs. Popp and Kerr, was accepted.

GENERAL FUND:

Checking	\$ 17,575.16	
Savings Accounts	74,018.91	
Government Bonds	50,000.00	
Government Bills	135,000.00	
		\$276,594.07

OBLIGATIONS:

Unearned Income for Operation:

General Fund	\$107,220.00	
Journal Fund	7,888.00	
AM - ERF	18,705.00	
		133,813.00

Net cash and Investments	
as of 6/30/67	\$142,781.07

SUMMARY OF ALL FUNDS:

	Cash	Investments	Total
General Fund	\$ 17,575.16	\$259,018.91	\$276,594.07
Journal Fund	92.40	—	92.40
Medical Defense Fund	4,315.86	30,000.00	34,315.86
Building Fund	2,422.63	—	2,422.63
Building Fund			
Auxiliary Donation	—	3,777.71	3,777.71
Student Loan Fund (old)	1,771.71	13,280.65	15,052.36
Kitchen Fund	—	3,002.80	3,002.80
	\$ 26,177.76	\$309,080.07	\$335,257.83

report of AMA delegates. Dr. Ochsner reported briefly on the actions of the AMA House of Delegates at the annual session in Atlantic City, June 18-22, 1967. (For complete report, see pages 1089-1095, August, 1967, *Journal*.)

On motion of Dr. Taylor, seconded by many, the Council voted that the members of the Council, the AMA delegates, and AMA alternate delegates be sent a copy of the AMA Handbook prior to the Council meeting which is held with the AMA delegates and alternate delegates immediately before the annual and interim sessions of the AMA, and following AMA meetings a summary of the actions of the AMA House of Delegates is to be sent to the members of the Council, the AMA delegates and AMA alternate delegates.

The chairman announced that Dr. Lester Bibler had been elected to membership on the Executive Committee of the AMA Board of Trustees.

DR. LESTER D. BIBLER, AMA Trustee, reported that the AMA Board of Trustees was reorganized at the June, 1967, AMA meeting. Dr. Wesley W. Hall is chairman; Dr. L. O. Simenstad, vice-chairman; Dr. J. B. Copeland, secretary-treasurer. The Executive Committee consists of Dr. Hall, Dr. Milford O. Rouse, Dr. E. Hendryson, Dr. B. E. Montmery, and Dr. Bibler. "Now, I understand that this has received quite a bit of comment over the country, and it has been good."

Dr. Edward R. Annis was elected a member of the Board of Trustees to complete the unexpired term of Dr. Homer Pearson, deceased.

Dr. Charles L. Hudson was elected president of AM-ERF, Dr. Gerald D. Dorman, vice-president, and Dr. Robert C. Long, secretary-treasurer, and the entire Board of Trustees will stand as a Committee on AM-ERF in the future.

Dr. Bibler discussed the question of how to keep interns at home and the causes of their migration. "We have had several inquiries, so we think it is time we did a little staff study on this."

Dr. Bibler also reported that Dr. Blasinme and Dr. Alvin J. Ingram, a member of the Board of Trustees, are going to Vietnam on a mission of the Department of State Health and Medical Facilities.

Matters Referred to Council by Executive Committee

1. *Suit Against Blue Cross*. Mr. Robinson, reporting for Judge Hamill, said the case had been venued to Hendricks county, the local counsel had been retained, and the defendant, the Hospital Corporation,

had been ruled to answer, "so that they will soon have to file some type of a pleading, and, of course, the case will continue from there."

2. *Resolution on Reference Committee Reports*. On motion of Drs. Petrich and Kerr, the Council accepted the Executive Committee's recommendation that the resolution passed by the House of Delegates in 1963 requiring reference committee reports to be available to delegates twenty-four hours in advance of the final meeting of the House be amended to provide that reports be completed twelve hours prior to the final meeting rather than twenty-four hours, in order to give the staff time to prepare this material for distribution.

3. *Hospital Emergency Rooms*. Dr. Everly, chairman, said the Executive Committee felt that the Council should establish some policy in the matter of servicing emergency hospital rooms. "As you all know, this is becoming a problem in many areas of the state. We have received several requests for our opinion concerning employment of physicians to man these facilities. The law is not specific. We do have several opinions by the courts that corporations cannot practice medicine."

Discussed by Drs. Coreoran and Shields, and Mr. Robinson.

By consent, this matter was referred to the Council Committee on Emergency Medical Services.

4. *Nominations for AMA Councils and Committees*. Dr. Everly reported that the ISMA had been invited to submit names to the AMA for nomination to the various councils and committees of the AMA. **The Executive Committee's suggestion that the Council review this matter and prepare a list of Indiana physicians for consideration for openings as they occur was referred to the president with the request that he appoint an Ad Hoc committee of councilors to study this matter, this committee to report back to the Council no later than the next Council meeting.** Dr. Rifner asked that the Council permit him to use the Executive Committee to compile this list. **On motion of Dr. Kerr, seconded by many, the Council concurred in this request.**

5. *Fort Wayne as 1968 Annual Convention Site*. In connection with the House of Delegates' action in selecting Fort Wayne for the site of the 1968 annual convention, the Executive Committee presented its views on the following items: (1) housing facilities; (2) technical and scientific exhibit space, and (3) attendance of members. The committee suggested that

perhaps the holding of the convention in Fort Wayne should be postponed until such time as adequate housing and exhibit accommodations are available, and that the 1968 meeting should be held in Indianapolis.

This matter was discussed in detail by Dr. Maurice Glock, chairman of the Fort Wayne Convention Arrangements Committee, who said that the invitation was extended in good faith, was accepted by the House of Delegates in good faith, and that the Fort Wayne members feel that they should go ahead and have the 1968 convention in Fort Wayne. It was also discussed by Drs. Popp, Coreoran, Kerr, and Shields and Mr. Waggener, following which Drs. Glock and Popp were asked to confer with their local society and report back to the next meeting of the Council.

6. *Professional Courtesy*. As recommended by the Executive Committee, **on motion of Dr. Taylor, seconded by many, the Council adopted the following statement of the AMA Judicial Council on "Professional Courtesy" as the policy of the Indiana State Medical Association:**

PROFESSIONAL COURTESY

Adopted by AMA Judicial Council

June 17, 1967

The custom of professional courtesy embodies the ancient tradition of fraternalism among physicians in the art which they share, and their mutual concern to apply their learning for the benefit of one another as well as their patients. The Judicial Council reaffirms and endorses the principle of professional courtesy as a noble tradition that is adaptable to the changing scene of medical practice.

Professional courtesy is not a rule of conduct that is to be enforced under threat of penalty of any kind. It is the individual responsibility of the physician to determine for himself and within his own conscience to whom and the extent to which he shall allow a discount from his usual and customary fees for the professional services he renders, and to whom he shall render such services without charge as professional courtesy.

The following guidelines are offered as suggestions to aid physicians in resolving questions related to professional courtesy:

1. Where professional courtesy is offered by a physician but the recipient of services insists upon payment, the physician need not be embarrassed to accept a fee for his services.

2. Professional courtesy is a tradition that applies solely to the relationship that exists among physicians. If a physician or his dependents have insurance providing

benefits for medical or surgical care, a physician who renders such service may accept the insurance benefits without violating the traditional ethical practice of physicians caring for the medical needs of colleagues and their dependents without charge.

3. In the situation where a physician is called upon to render services to other physicians or their immediate families with such frequency as to involve a significant proportion of his professional time, or in cases of long-term extended treatments, fees may be charged on an adjusted basis so as not to impose an unreasonable burden upon the physician rendering services.

4. Professional courtesy should always be extended without qualification to the physician in financial hardship, and members of his immediate family who are dependent upon him.

7. *Convention Site, 1968.* On behalf of the Marion County Medical Society, Dr. Schuster invited the association to meet in Indianapolis in 1968.

Economic and Organization Matters

1. *Report of Council Committee to Study Membership Matters.* In the absence of Dr. Otis Bowen, chairman, **Dr. Popp read the following report which was accepted, with the exception of the last paragraph, on motion of Dr. Popp, seconded by many:**

The Ad Hoc Committee to Study Membership Matters, including remission of state dues, which was organized at the April 9, 1967, Council meeting, has submitted the following report:

June 11, 1967

To the Council, ISMA:

In order to be consistent in the remission of dues of members of the ISMA for reasons of hardship, a statement of policy has become necessary.

Remission shall mean to pardon or forgive the paying of future dues and shall not mean refund of previously paid dues.

The fourth paragraph of Section 12, Chapter XXVII of the ISMA Bylaws outlines the method of application for remission of dues and specifically denotes that financial hardship be the reason.

Subsection (6) of subsection (D) of section 1 of Chapter III of Bylaws of the AMA permits exemption of dues for members retired from active practice. To be consistent with the AMA Bylaws it is recommended that retirement from active medical practice be considered as "hardship."

The committee recommends that dues include the right to receive the *ISMA Journal*

al; anyone whose dues have been remitted will not receive *The Journal* except by subscription.

The Council cannot act on an application for remission of dues unless the application is adequately supported by written reasons for the application. It is the responsibility of the county medical society's secretary, in the event the county society remits a member's dues, to recommend in writing to the councilor of his district the remission of state association dues of said member of the society showing why such recommendation should be granted.

The councilor shall present the recommendation to the Council at its next regular meeting and the Council shall have the power to remit or refuse to remit such dues.

The Council committee believes that the thinking of the entire Council be the basis for a decision as to whether or not the application be required annually or that it be permanent until reapplication is made by the member whose dues has been remitted.

Respectfully submitted,
DONALD M. KERR, M.D.
MILTON F. POPP, M.D.
A. M. DONATO, M.D.
P. J. V. CORCORAN, M.D.
OTIS R. BOWEN, M.D., Chairman

At the request of the chairman Dr. Popp re-read the final paragraph of the Membership Committee's report:

"The Council committee believes that the thinking of the entire Council be the basis for a decision as to whether or not the application be required annually or that it be permanent until reapplication is made by the member whose dues has been remitted."

Mr. Waggener explained that once a physician's dues has been remitted by the Council, no further action is taken unless the county society sends the man's name in as an active member.

On motion of Drs. Donato, Rifner and Green, the Council voted that the remission of state dues should be handled in the same manner as it has been in the past, "as the local society will let us know at the state level whether or not a member is reactivated."

Following discussion by Drs. Popp and Rifner, **on motion of Drs. Rifner and Dukes, the Council voted that the headquarters office shall ascertain from the county society secretaries each year if members whose dues have been remitted are still eligible for remission of dues on the basis of financial hardship.**

2. Remission of state dues.

a. **On motion of Drs. McIntosh and Rifner, remission of state dues of retired member of the Fifth District was approved because of financial hardship.**

On motion of Drs. McIntosh and Popp, remission of state dues of another member of the Fifth District who has discontinued practice because of ill health was approved.

b. **On motion of Dr. Donato, seconded by many, remission of state dues of a member of the Seventh District, because of retirement from practice due to ill health was approved.**

c. **On motion of Drs. Steen and Popp, remission of state dues of member of the Tenth District who serving as a missionary in Africa was approved.**

d. **On motion duly made, seconded by Dr. Shields, remission of state dues of a member of the Thirteenth District, due to discontinuance of practice because of illness and financial hardship, was approved.**

On motion of Drs. Rifner and McIntosh, remission of state dues of another member of the Thirteenth District who has retired from practice was approved.

3. *Election of two members to the Trustees Committee of Indiana Medical Education Foundation* for three-year term ending October 31, 1970, was deferred until the October meeting of the Council.

4. *District nominations for Blue Shield Board of Directors for the three-year term beginning March, 1968, and ending March, 1971, were reported as follows:*

District 1—G. W. Willison, Evansville, Internal Medicine, renominated

District 5—Fred W. Dierdorf, Terre Haute, Anesthesiology, nominated

District 8—F. W. McDowell, Muncie, General Surgeon, renominated

District 9—Barton C. Bridge, Lafayette, General Practice, nominated

District 12—M. F. Miller, Fort Wayne, Ob-Gyn, renominated

By appropriate motions, duly seconded, all of the above nominations were confirmed by the Council.

5. *Reports from Commissions and Committees.*

a. *Committee on Student Loan.* Dr. Lester D. Bibler, chairman, reported that of July 15, 1967, 70 loans, totaling \$58,900.00, had been granted under the Guaranteed Loan Plan with the Indiana National Bank which was instituted December 1, 1963.

Under the loan plan operated by the association from October, 1955, to December

r 31, 1963, 25 physicians are still making payments on their notes. As of July 1967, the amount due from these loans is \$9,284.29. Dr. Bibler said that pertinent letters had been sent to all physicians in this group who are delinquent in the payment of their loans and returns from these letters have been good.

b. Commission on Convention Arrangements. Dr. Taylor took the chair.

On motion of Dr. Steen, duly seconded, the Council voted "to establish this year a dinner for the councilors and alternate councilors, with their wives; this to be an affair in honor of the president at which time no business would be transacted, for which the president's wife makes the decision as to whether the dress is formal or not and the place where the dinner will be held."

Dr. Rifner suggested that the place be designated by the Executive Committee or the Convention Arrangements Commission rather than the president's wife, and this suggestion was accepted by Dr. Steen. It was also agreed that the individual councilors and alternate councilors would assume the expense in connection with this dinner meeting. The dinner will be held Tuesday evening, October 10.

Motion carried.

Dr. Steen resumed the chair.

c. Commission on Public Health. Dr. Kerr read the following report from the Commission on Public Health:

The Commission on Public Health has concerned itself with three major points since its last report to the Council. A review of the replies to our questionnaire at the Junior-Senior Day has been made. Admittedly, this is only a sample and has no statistical validity; however, these replies indicate that the young physician's relationship to his community for service and to his education for achievement of his potential have either been neglected or ineffectively presented during his medical education. Only one of the replies indicated that educational possibilities were significant in choosing an internship. One can sympathize with the youthful desire to "escape" to the "greener grass" and to see a bit more of the world than Bloomington and Indianapolis presents. However, there is a glaring lack of information regarding this state's present cultural and recreational offerings and possibilities as well as regarding the wide spread of practice opportunities. Motivation for selection of internships and residencies does not seem to be on the firm basis of opportunities for professional education and advancement. To many, the money they

would earn seemed significant. A few indicated they planned to pick a place where they wanted to live and then would find educational opportunities in that area. One fellow summed up the feeling of many with "wine, women, water and climate." Again, these replies can only be indicators. Had questions been asked in a different manner, one might have received an entirely different reply. I leave the significance of this information for the Council to determine. Our only comment is that there seems to be a need for more information on course offerings at Indiana University School of Medicine and their specific effect on students' motivation for continued education and choice of practice site.

Comments regarding the direction and presentation of Junior-Senior Day were much as had been anticipated and presented to the Council at its previous meeting. The commission is now proceeding as the Council has directed.

The Indiana Inter-Agency Council on Smoking and Health has requested through this commission that an official representative of the Indiana State Medical Association be appointed to serve with the council. This group was formally organized and a meeting called for Monday, July 17 at the Indiana State Board of Health. The council has already made direct contact with each of the school representatives within the state, and almost two-thirds of them have responded with requests for further information on the council's program. Briefly, the program is directed to in-service training of teachers as regards the effects of smoking and will not participate directly in the student presentations. It has been proposed that physicians would assist with this program at the local level and those interested in health education would be directly involved in formulating the program. With the Council's permission, the chairman of the Commission on Public Health would attend this first meeting as representative of the Indiana State Medical Association.

On motion of Drs. Kerr and Popp, the Council voted approval of the chairman of the Commission on Public Health attending the first meeting of the Indiana Inter-Agency on Smoking and Health. It is requested that a permanent representative, preferably someone else, be appointed to serve in this capacity. It is suggested that consideration be given to members of the commission's Committee on School Health or members of the Commission on Voluntary Health Agencies.

Members of the commission met at the Monroe Reservoir on June 29 for a presentation on environmental health problems of developing recreational areas. While the

attendance by commission members was not very good, those members present were quite impressed with the necessity for physicians' participation in the development of these recreational areas. At this particular meeting it was possible for us to demonstrate the cooperative efforts of the city of Bloomington, the county government of Monroe, the state government, as represented by the Department of Conservation and the State Board of Health, and the United States Government as represented by the Corps of Engineers. All of these people made it possible for this facility to come into being and are actively involved in preserving the beauty, the recreational capabilities and, perhaps more significant, the essential usage of the reservoir for water supply and flood control. Without adequate safeguards, none of these could be possible for long. Specifically, the group toured the ultra-modern water treatment installation of Bloomington City under the able guidance of the Honorable John Hooker, Mayor of Bloomington. The developing shore-line of the lake was toured to demonstrate the many public uses now available or planned for the far distant future. The newly installed Boy Scout camp of the Central Indiana Council, Ransburg Ranch, was toured to demonstrate the possibilities for small water treatment systems and sewage disposal systems applicable to a limited area that would meet all of the requirements for health and safety of the inhabitants of that area.

Just as the physicians, individually and collectively, as well as the local boards of health have cooperated to support stringent health regulations and standards for use of this particular area, it will be essential for the Indiana State Medical Association and the physicians involved in other developing areas to become similarly involved. There are also many state recreational areas whose usefulness have been greatly damaged by inadequate sanitary regulations and abuses by the people using that area's facilities. The requirements vary as much as the terrain and geological features vary from one portion of the state to another, but with technical competence, the accomplishing of a goal of safe, healthful and permanently useful area can be made with the support of individual physicians and organized medicine.

Thomas O. Middleton, M.D.
Chairman—Commission on
Public Health

On motion duly made, seconded by Dr. Taylor, the Council accepted this report.

The chairman of the Council referred to

the president the matter of appointment of a permanent representative of the Indiana State Medical Association to serve with the Indiana Inter-Agency Council on Smoking and Health.

New Business

Dr. Taylor took the chair.

1. *Change in name of Council.* On motion of Dr. Steen, seconded by several, the Council voted to recommend to the Commission on Constitution and Bylaws that the Constitution and Bylaws be amended to change the name of the Council to the Board of Trustees of the Indiana State Medical Association in keeping with the terminology used in the American Medical Association and in most of the other state medical associations.

2. *Speaker of House of Delegates.* Dr. Steen moved that the Council recommend to the Commission on Constitution and Bylaws that an office of Speaker of the House of Delegates be established, this not to be an elective office but that it be the immediate past-president. "The immediate past-president would thereby automatically become a member of the Executive Committee which would preserve his usefulness for an additional year; the knowledge he had gained through being the president could be utilized for an additional year, not only on the Executive Committee, but throughout the state medical association."

Motion seconded by several. Discussed by Drs. Rifner and Shields.

Dr. Steen moved to amend his motion to include that the Speaker of the House would be an ex-officio member of the Executive Committee without a vote. Motion duly seconded.

Discussed further by Drs. Corcoran, Shields, Steen, Rifner, Neumann, Dukes, Harshman and Kerr, and Mr. Waggencer.

On voting, the motion, as amended, was lost.

Dr. Steen then moved that the Council suggest to the Commission on Constitution and Bylaws that an amendment to the Constitution and Bylaws be prepared establishing an office of Speaker of the House, and that whoever shall be selected Speaker of the House shall be a member of the Executive Committee, ex-officio, without vote. Motion duly seconded.

Discussed by Drs. Rifner, Dukes and Donato.

Dr. Donato moved to amend the motion to specify that the Speaker of the House be a member of the Council, with vote, rather than a member of the Executive Committee without a vote. Motion seconded by Dr. Olvey.

The amendment was discussed by Drs. Steen and Popp, following which motion was made by Dr. McIntosh and duly seconded to table the matter of Speaker of the House. Motion to table put to vote, and defeated.

Dr. Donato's motion amending Dr. Steen's motion to include that the Speaker of the House shall be a member of the Council with a right to vote was put to vote, and carried.

On voting, the Council adopted the original motion, as amended.

3. *Council meeting in Chicago.* On motion of Drs. Steen and Kerr, the Council voted to meet in Chicago on Saturday, September 16, to tour the AMA headquarters, and to meet again on Sunday, September 17, 1967, for a business meeting.

Dr. Steen resumed the chair.

Matters from Council Committees

1. *Council Committee on Economics and Fiscal Matters.* Dr. Corcoran, chairman, reported that the committee had met on July 29 and had considered the following matters:

a. *Permanent home for Marion County Medical Society.* Dr. Corcoran outlined the requirements of the Marion County Medical Society and discussed the options that the state medical association might offer.

Dr. Corcoran moved the following recommendation: The committee recommends that the Council authorize the president to direct the Building Committee to assess present and long-term needs of the state medical association. And also that the president ask the executive secretary independently to make his recommendations as to what he and his staff see as the needs and our deficiencies and what we should do, and when these are brought in that they be reported to the Executive Committee which, if it wishes, could employ some professional opinion if it is receptive. It might be an architect or an engineer, to get feasibility studies, these to be reported back to the next Council meeting for further consideration, mindful that certain possibilities would undoubtedly need to be referred to the House of Delegates for final authorization. Motion seconded by Dr. Kerr.

Discussed by Drs. Rifner, Shields and Donato, following which Dr. Corcoran said, "Implicit in my motion was that the Council would be receptive to offering something to Marion County if it could be worked out. This, of course, I think

is the premise and possibly for clarity should offer that first."

Dr. Corcoran then moved to amend his motion to include that the Council favors providing space to the Marion County Medical Society on some basis. Motion seconded by Dr. Olvey.

In the discussion that followed it was agreed that before a final decision is made this matter would have to be presented to the House of Delegates. It was also understood that the original Building Committee, composed of Dr. Everly, chairman, Dr. Frederic W. Brown, Fort Wayne, R. Case Hammond, Evansville, and Jack Shields, Brownstown, would serve studying and making the decision in this matter, with a report to be made at the meeting of the Council on September 1967.

The motion to amend the original motion was put to vote, and carried.

Dr. Corcoran's motion, as amended, was put to vote, and carried.

b. *Investment of association funds.* Dr. Corcoran moved "that an up-dated investment program, geared to current ideas be suggested by the treasurer and the assistant treasurer, that these officers report to the Executive Committee any recommendations that they may have, either individually by conference, or by enlisting professional advice, and that thereafter a change in the investments made by the Executive Committee be reported at the next meeting of the Council, and that continuing reports be given to the Council." Motion seconded by several, put to vote, and carried.

c. *Special or unusual mailings.* Dr. Corcoran moved that before special mailings are made by the headquarters office that these be approved by the Executive Committee, or in an emergency, by the president. Motion duly seconded.

Dr. Popp amended the motion to include "that all special mailings made a matter of record and be reported to the Council by the Executive Committee." Motion seconded, put to vote, and carried unanimously.

On voting, the motion, as amended, that before special mailings are made they be approved by the Executive Committee, or the president, and that they be recorded and reported to the Council by the Executive Committee was adopted by the Council.

d. *Per diem allowances.* Dr. Corcoran reported that his committee had discussed this subject but it felt no recommendations could be made at this time. Dr. Steen referred this matter back to the Committee.

Economics and Fiscal Matters for further consideration.

e. *Recommendations of past-presidents.*
f. **Corcoran's motion that the past-presidents, because of their past experience in association work, be invited to submit any recommendations ideas they may have to the Council, as taken by consent, and Dr. Steen directed Dr. Corcoran to write the past-presidents for this information.**

2. *Council Committee for Orientation of New Members.* Dr. Donato, chairman, reviewed the action already taken on this object. The report of the Commission on Special Activities, to which this matter was referred, outlining a proposed program and requesting an appropriation of \$3,000.00 to underwrite the program, was referred to the Executive Committee and the Execu-

tive Committee, by consent, "agreed to table any action on this request until after the meeting of the House of Delegates in October."

Dr. Shields moved that the Council Committee for Orientation of New Members present a resolution concerning this matter to the House of Delegates. Motion seconded by Dr. Kerr.

Dr. Donato commented that this matter should be referred to the Council Committee on Economics and Fiscal Matters inasmuch as it involves an expenditure of \$3,000.00.

Dr. Shields made an editorial change in the motion to read, **"that the appropriate committee present a resolution to the House of Delegates."**

THE CHAIRMAN: The motion is to refer this report to the appropriate

committee or commission, to prepare a resolution to be presented to the House of Delegates. . . . This just goes back to that commission (Special Activities) to make sure that it incorporates that in its report, which it might not do otherwise.

Motion put to vote, and carried.

Date for Next Council Meeting

The chairman called attention to the date for the next meeting of the Council which was set earlier in the meeting for Sunday, September 17, 1967, at the AMA headquarters office, Chicago.

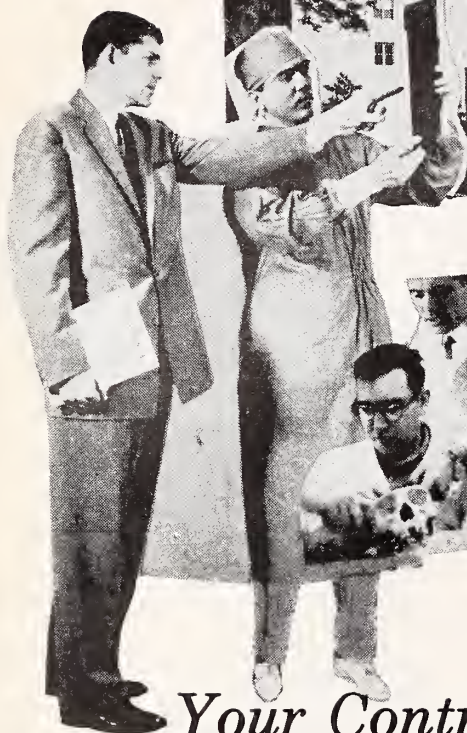
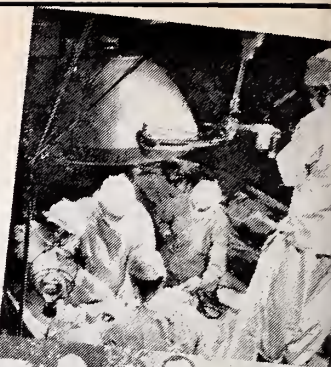
There being no further business, the meeting was adjourned.

New AMA Film Available Soon

As a further means of fulfilling its role of encouraging young men and women to enter careers allied to medicine, the American Medical Association is developing a new film, "Horizons Unlimited," which is expected to be available for distribution this fall.

Designed to tie in with the Association's paperback of the same name, the film, developed in a hospital setting, will depict approximately 12 rewarding careers in the health field and call attention to the wide variety of others.

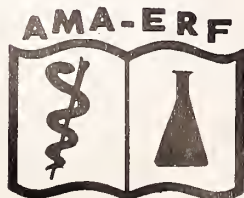
"Horizons Unlimited" will be produced in color and will run approximately 28 minutes. It will become the only recently produced film covering a broad variety of health career opportunities and is intended to replace the time-worn film, "Helping Hands for Julie," developed by the AMA and American Hospital Association through a grant from E. R. Squibb and Company, in 1958. The new film is being developed exclusively by the AMA.



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

COMMERCIAL ANNOUNCEMENTS

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

EASTERN WISCONSIN CLINIC in rapidly growing community of 50,000 desires board-eligible or certified physicians in obstetrics and gynecology, pediatrics, orthopedic surgery, urology and otolaryngology. Well-equipped clinic and excellent hospital facilities. Lake shore location offers ample recreational facilities. Attractive financial plan leading to early full partnership. Full expenses paid for applicants invited to interview. Call or write: F. L. Hildebrand, M.D., Riverside Clinic, Menasha, Wisconsin.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION**, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

NEEDED:

G. P. in rapidly growing residential community near industrial complex.

Hospital 15 minutes — Chicago Loop 60 minutes
Lake Michigan 5 minutes

Office available — For details

William Robertsan, M.D., 600 E. Morgan,

Chesterton, Indiana — Ph. 926-1721 or

Ann Carter — Chesterton 926-1138

INTERNISTS: Unappreciated practice opportunity in town of 17,000 with new 100-bed hospital. Office space immediately available in new professional building. General practitioners also needed. Contact P. E. Daermann, M.D., 1775 N. Jefferson, Huntington, Ind. 46750. Phone (219) 356-4520.

INTERNIST: Position available for a Board Certified or qualified internist in a 200-bed modern, progressive general hospital with 104-bed medical service; fine opportunity in a city of 185,000 near Chicago and Detroit; liberal salary range dependent on qualifications; excellent fringe benefits; must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

POSITION AVAILABLE: For physician with same psychiatric training or experience to head a 24-bed intensive treatment psychiatric service; extensive training or experience not required; excellent opportunity to develop in the field of psychiatry in a city of 185,000 near Chicago and Detroit. Must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Excellent fringe benefits. Liberal salary range dependent on qualifications. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

WANTED: G. P. for aggressive town of 1,300 in southern Indiana. New Sears-Roebuck medical clinic to be built in immediate future. Clinic available rent free first 90 days; reasonable rent thereafter or may purchase. Contact Gordon A. Triplett, Box 37, Osgood, Ind. 47037.

WANTED: Physician or physicians to operate emergency room at St. Francis Hospital. Four doctors needed for full-time coverage. Guaranteed minimum annual stipend. Contact committee members: Dr. A. L. Blake, Dr. Charles Dill or Dr. Robert Nagan, St. Francis Hospital, Beech Grove, Ind.

MODERN OFFICE SPACE AVAILABLE AT PRIME EASTSIDE LOCATIONS

• Community Medical Building

• Eleventh & Arlington Avenue

Newly decorated professional offices. Pharmacy at both locations. For information contact

JUSTUS COMPANY

357-8055

Mr. Ernst

PSYCHIATRIC RESIDENCIES: Accepting applications for January and July, 1968. Balanced didactic-clinical program providing extensive, varied experience with both inpatient and outpatient adults and children. Fully approved 3 year training. Three year plan: \$8,978; \$9,417; \$10,210. Five year career plan: \$10,231; \$11,797; \$13,739; \$17,497; \$18,458. Located in Michigan's serene, scenic water wonderland. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan, 49684. An equal opportunity employer.

ANESTHESIOLOGIST: Community of 80,000 in north central Indiana seeks board certified or board eligible anesthesiologist. Hospital presently engaged in a construction and remodeling program which will have all new surgical facilities. Interested parties contact Box 340, The Journal, Indiana State Medical Association, 3935 N. Meridian Street, Indianapolis, Ind. 46208.

ASSISTANT MEDICAL DIRECTOR: Needed for full-time work in home office of large midwest life insurance company in city of 160,000 population. Work week of five days, no night calls, annual vacations plus holidays, fringe benefits and non-contributory retirement plan. Training in internal medicine and electrocardiography desirable. Preferred age 30 to 40. Salary subject to discussion. Write Box 346, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

October 1967

Volume 60

No. 10

Abbott Laboratories	1333-38	Mutual Medical Insurance, Inc.	143
Ames Company, Inc.	3rd Cover	National Drug Company, The	142
Burroughs Wellcome & Co., Inc.	1379	Parke, Davis & Company	2nd Cover
Campbell Soup Company	1355	Philips Roxane Laboratories	1410-1
Carnation Company, The	1406-07	Pitman-Moore Company	1428-29, 145
Coca-Cola Company	1443	Poythress, Wm. P. & Co., Inc. ..	1426, 1440, 1441, 145
Dorsey Laboratories	1343, 1409, 1447-50	Professional Life & Casualty Company	1444-4
Geigy Pharmaceuticals	1394-95, 1432-33	Quality Leasing	144
Glenbrook Laboratories	1317	Robins, A. H. Company, Inc.	1323-25, 1380, 139
Hanger, J. E., Inc.	1454	Roche Laboratories	4th Cover
Harding Hospital	1405	Rorer, William H., Inc.	133
Heid's Shoe Store	1443	Sandoz Pharmaceuticals	1424-2
Hynson, Westcott & Dunning, Inc.	1315	Searle, G. D. & Co.	1396-9
Indiana Medical Bureau	1415	Smith Kline & French Laboratories	138
Lederle Laboratories	1375, 1413-14	Stuart Company, The	131
Lilly, Eli & Company	1344, 1356-58, 1398-1400, 1436-37	Syntex Laboratories, Inc.	1329-32, 1416-1
Linder, Louis & Son	1439	Wabash Valley Hospital	137
Medical Protective Co. of Ft. Wayne	1438	Winthrop Laboratories	1321, 1367-7

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

Indiana State

Vol. 60 • No. 11

November 1967 Indianapolis, Indiana

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION



Dilantin[®]

(diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals[®] containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

015R67





LACTINEX[®]

TABLETS & GRANULES

■ to help restore and stabilize
the intestinal flora

■ for fever blisters and canker
sores of herpetic origin

LACTINEX contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

First introduced to help restore the flora of the intestinal tract in infants and adults,^{1, 2, 3, 4} LACTINEX has also been shown to be useful in the treatment of fever blisters and canker sores of herpetic origin.^{5, 6, 7, 8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

References:

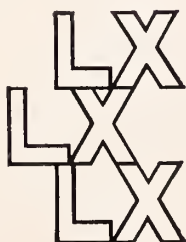
- (1) Siver, R. H.:
CMD, 21:109,
September 1954. (2)
Frykman, H. H.: Minn.
Med., 38:19-27,
January 1955. (3)
McGivney, J.: Tex.
State Jour. Med.,
51:16-18, January
1955. (4) Quehl,
T. M.: Jour. of Florida
Acad. Gen. Prac.,
15:15-16, October
1965. (5) Weekes,
D. J.: N.Y. State Jour.
Med., 58:2672-2673,
August 1958. (6)
Weekes, D. J.: EENT
Digest, 25:47-59,
December 1963. (7)
Abbott, P. L.: Jour.
Oral Surg., Anes., &
Hosp. Dental Serv.,
310-312, July 1961.
(8) Rapoport, L. and
Levine, W. I.: Oral
Surg., Oral Med. &
Oral Path., 20:591-593,
November 1965.

**HYNSON, WESTCOTT
& DUNNING, INC.**



BALTIMORE, MARYLAND 21201

(LX04)



Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

The Krannert Institute of Cardiology , Charles Fisch, M.D., Director, Indianapolis . . .	1515
High Fidelity Electrocardiography , Gary J. Anderson, M.D., Indianapolis	1516
Selective Coronary Cinearteriography , William C. Elliott, M.D., Indianapolis	1519
Cardiovascular Uses of Diagnostic Ultrasound , Harvey Feigenbaum, M.D., Indianapolis	1522
Coronary Blood Flow , Suzanne B. Knoebel, M.D., Paul L. McHenry, M.D., Indianapolis	1526
Electrophysiology Laboratories , Kalman Greenspan, Ph.D., Robert E. Edmands, M.D., Indianapolis	1537
Exercise Laboratory , John W. Jordan, M.D., Indianapolis	1552
Malformations in Plants Caused by a Mold Product, Malformin (Report on the American Cancer Society-supported work at the laboratory of Dr. Professor R. W. Curtis, Lafayette)	1554
X-Ray Conference: Arteriographic Assessment of Internal Mammary Lymph Node Metastases , Erich K. Lang, M.D., Indianapolis	1556
Fractures and Orthopedic Problems: Dislocation of the Hip with Femoral Shaft Fracture , Alois E. Gibson, M.D., Richmond	1558

EDITORIALS

Drugs—Judgment or Regulation?	1560
The Killer (Guest)	1561
Publisher's Memo (Guest)	1561
Young Driver's Record Worse (Guest)	1562
Historical Notes , R. B. Smallwood, M.D., St. Petersburg, Fla.	1562
Editorial Notes	1563

SPECIAL FEATURES

G. O. Larson, M.D., President, 1967-68	1564
Meet The Journal Staff	1572
Indiana School for the Blind , Diane B. Brashear, M.S.W., Indianapolis	1574
Day by Day with the FDA	1577

REGULAR FEATURES

Month in Washington	1492
Fourth Estate	1496
What's New?	1501
Letters to the Editor	1504
President's Page	1566
The Woman's Auxiliary Reports to ISMA	1571
News from Indiana University School of Medicine	1576
What's Ahead for Blue Shield? (One of a Series)	1578
Medicine at Law	1581
Abstracts, Book Reviews	1585
News Notes	1591
Future Meetings, Seminars, Courses	1596
Deaths	1598
Annual Meeting Dates of Professional Medical and Allied Organizations	1599
Board of Health Report	1602
From The Journal 50 Years Ago	1603
County, District News	1604

BUSINESS

Executive Committee: Sept. 16, 1967	1606
The Council: Sept. 17, 1967	1607

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glassy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Paplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 1515.

ACID GAS

DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.

Stuart

Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545
ANNUAL CONVENTION—OCTOBER 14-17, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

President-Elect—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scottsburg 47170.

Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian, Indianapolis 46208.

Legal Counselor—Mr. Robert Hollowell, 1440 Consolidated Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1968

Section on Surgery:

Chairman—Donald M. Schlegel, Indianapolis
Vice-chairman—Henry Larzelere, Marion
Secretary—Austin Gardner, Indianapolis

Section on Internal Medicine:

Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—M. Richard Harding, Indianapolis
Vice-chairman—David E. Brown, Indianapolis
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—William M. Matthews, Indianapolis
Vice-chairman—Merle E. Pickett, Fort Wayne
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Jay S. Reese, Martinsville
Vice-chairman—Robert Mouser, Indianapolis
Secretary—Richard Juergens, Fort Wayne

SECTION OFFICERS 1967-68

Section on Obstetrics and Gynecology:

Chairman—Robert M. Reid, Columbus
Vice-chairman—Tom W. Wachob, Jr., Kokomo
Secretary—Charles R. Echt, Indianapolis

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Richard A. Silver, Indianapolis
Vice-chairman—John A. Robb, Indianapolis
Secretary—Edwin F. Koch, Jr., Muncie

Section on Nervous and Mental Diseases:

Chairman—Gordon T. Brown, Indianapolis
Vice-chairman—James E. Benson, Elkhart
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:

Chairman—Robert J. Frost, Michigan City
Vice-chairman—
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	Don E. Wood Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

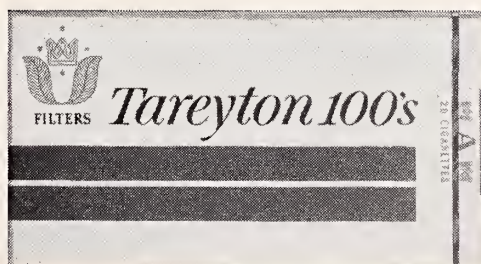
Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis

**If you could put
Tareyton's charcoal filter
on your cigarette,
you'd have
a better cigarette.**



Of course we can't guarantee it'll smoke as smooth as a Tareyton.



New Tareyton 100's with the charcoal filter. © The American Tobacco Company

ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Glock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E Rogers Smith, Indianapolis

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salon, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Gootee, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Glock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholty, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hoyda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finrock, Elkhart; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Okla W. Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Anderson; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseny, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordsville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salon, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammon. Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry G. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donalo M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordsville.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfort; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Hobgood, Evansville	
2.	C. Philip Fox, Washington	J. S. Brown, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Frank B. Bard, Crothersville	Harold E. Miller, Seymour	
5.	Thomas J. Conway, Terre Haute	Arnold W. Kunkler, Terre Haute	
6.	Paul Inlow, Shelbyville	Perry Seal, Brookville	
7.	Jay Reese, Martinsville	James H. Gossman, Indianapolis	
8.	Donald E. Spahr, Portland	Joseph F. Vormohr, Portland	
9.	Nolan Hibner, Monticello	Max Fields, Monticello	May 16, 1968, Monticello
10.	John J. Reed, Hobart	Raymond Doherty, Crown Point	
11.	Charles Wise, Camden	Fred Poehler, La Fontaine	
12.	Max M. Gitlin, Bluffton	Berniece Williams, Fort Wayne	May 15, 1968, Angola
13.	E. C. Mueller, LaPorte	John Hildebrand, South Bend	

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS. MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each **Tussagesic[®]**

timed-release tablet contains:

Triaminic [®]	50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine maleate 12.5 mg., pyrilamine maleate 12.5 mg.)	
Dextromethorphan hydrobromide	30 mg.
Terpin hydrate	180 mg.
Acetaminophen	325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. **Side effects:** Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. **Precautions:** The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

Fast delivery by your Dorsey
Representative

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence
Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe

Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Griffith Marr, Columbus
A. L. Coddens, Earl Park
James R. McAfee, Lebanon
Don J. Wagoner, Burlington
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
J. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazey, Washington
Alfred K. Rhodes, Lawrenceburg
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
James Y. McCullough, New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waitt, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
James S. McElroy, New Castle
Donald Fields, Kokomo
Barth E. Wheeler, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisett, Madison
George Brown, Greenwood

Boyd K. Black, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford
Robert D. Williams, Anderson
Dwight W. Schuster, Indianapolis

John K. Guild, Plymouth
Parker W. Snyder, Peru
V. G. Viray, Crawfordsville
Elery T. Drake, Martinsville
John Parker, Goodland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington

John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Glackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Philip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
H. H. Dunham, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David G. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave.,
Fort Wayne

Mr. Larry L. Pickering, Exec. Secy.,
212 Med. Ctr. Bldg., Fort Wayne
Donald L. Sandlin, 2530 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
Katherine A. Jackson, 95 E. Oak St., Zionsville
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street,
Logansport

Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St.,
Frankfort

Hamlin B. Lindsay, 511 E. Main St., Washington
J. Kenneth Jackson, 223 Mechanic St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntingburg
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman

Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert G. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren

William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St.,
Franklin

John S. Murray, 317 Security Bank Bldg.,
Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave.,
Gary

Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave.,
LaPorte

Joseph D. McPike, 1714 24th St., Bedford
William M. Stimson, 333 Jackson St., Anderson
John O. Butler, 234 E. Southern Ave.,
Indianapolis

Mr. Arthur G. Loftin, Exec. Secy., 2902 N.
Meridian, Indianapolis
M. George Rosero, 921 Lake Shore Dr., Culver
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 10½ N. Main St., Martinsville
Arthur Schoonveld, Brook
Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Kermit Q. Hibner, 117 N. Grant St.,
Bloomington

Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital,
Valparaiso

Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe,
South Bend

Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E.
3rd., Evansville

Robert L. Melssel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City

Dulcolax[®]

isacodyl

DU-5555 R

Few drugs work as predictably as Dulcolax. You can expect that when your office patient takes Dulcolax at home, it will be as effective as you said it would be. Your patient will be gratified, too.

The reliability of Dulcolax stems from its unique mode of action. The drug works directly on nerve endings in the colonic mucosa, producing normal peristalsis throughout the large intestine. It does not rely on systemic absorption for its effect.

This reliable action provides prompt relief of constipation. It also makes Dulcolax par-

ticularly useful for prepping the bowel for special procedures. In short, it makes Dulcolax ideal for your office practice.



Dulcolax acts so surely that the time of evacuation can often be closely predicted. Dulcolax tablets taken at night almost invariably result in a bowel movement soon after waking the following morning. Dulcolax suppositories generally work in 15 to 20 minutes, almost always within the hour.

General Dosage Information: *Adults:* When an ordinary laxative effect is desired, 1 to 3 tablets or 1 suppository usually suffices. Tablets must be swallowed whole, not chewed or crushed, and should not be taken within one hour of antacids or milk. *Children:* 1 or 2 tablets, depending on age and severity of condition. Tablets must not be given to a child too young to swallow them whole. For infants and children under 2 years of age, half a suppository is usually effective. Above this age a whole suppository is usually advisable. **Side Effects:** As with any laxative, abdominal cramps are occasionally noted, particularly in

severely constipated persons. High dosage may result in loose, unformed stools. **Contraindication:** Contraindicated only in acute surgical abdomen. **Availability:** Tablets (5 mg.) and suppositories (10 mg.). By prescription or recommendation.

Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation, Ardsley, N.Y.





"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning — May be habit forming),
Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin'
Compound with Codeine remains unchallenged.

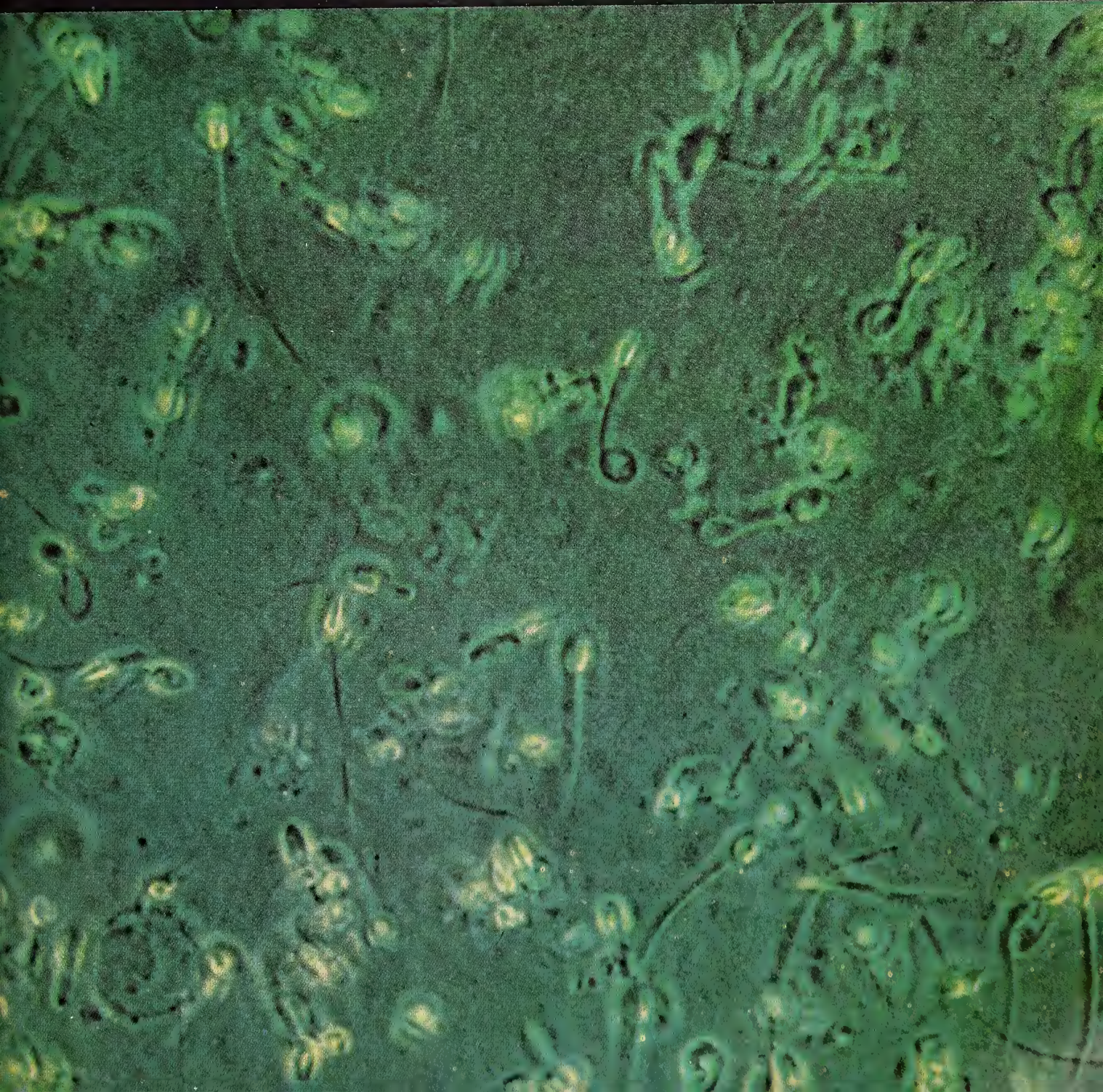


BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl-1.

(norethindrone 1mg c̄ mestranol 0.05mg)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstruallike syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX 
 LABORATORIES INC., PALO ALTO, CALIF.

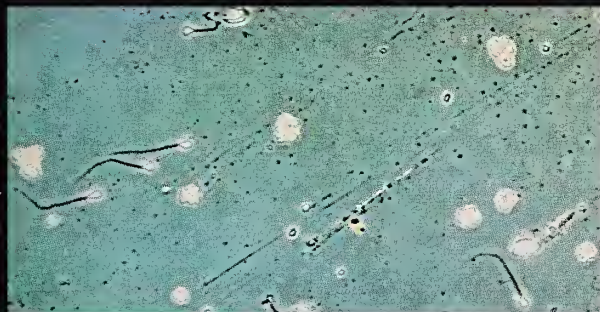
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

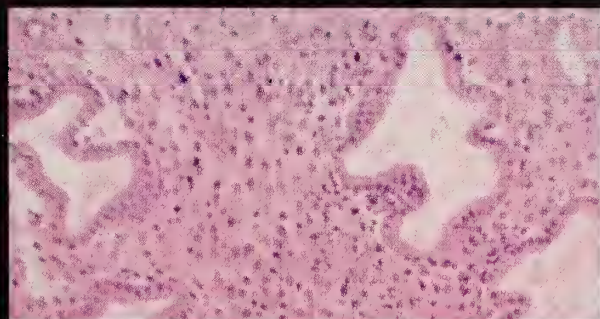
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

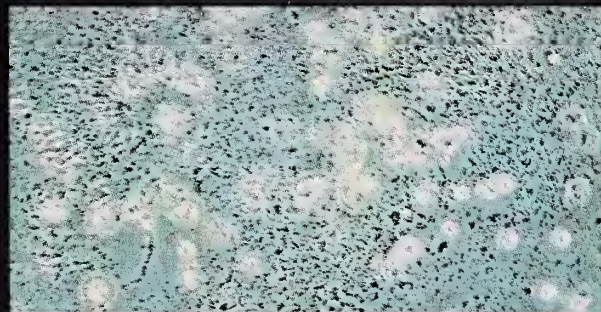


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

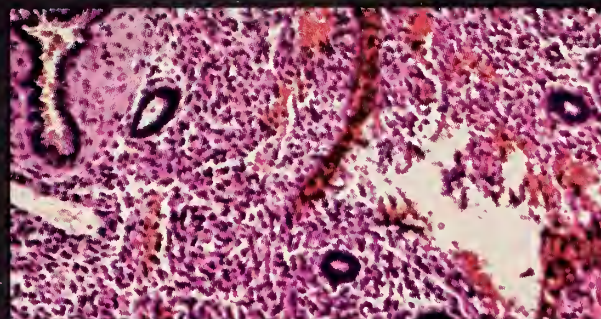
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl-1[®]
(norethindrone 1mg, & mestranol 0.05mg.) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydro-

cortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often

where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the “economy” of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar[®]
fluocinolone acetonide





For everyday topical steroid therapy

Synalar® 0.01%

fluocinolone acetonide

provides economy in two practical dosage forms

For general use, the most economical and widely applicable concentration of Synalar is 0.01% Cream in a water-washable, vanishing cream base. Synalar Solution 0.01% is especially valuable in dermatoses involving moist, intertriginous areas or hairy sites where creams and ointments do not spread or penetrate readily. Synalar Solution is a unique dosage form—clear, nongreasy, cosmetically elegant.

Product Information

Contraindications: Tuberculous, fungal, and most viral lesions of the skin (including herpes simplex, vaccinia, and varicella). Not for ophthalmic use. Contraindicated in individuals with a history of hypersensitivity to any of the components.

Precautions: Synalar preparations are virtually nonsensitizing and nonirritating. However, the solution may produce burning or stinging when applied to denuded or fissured areas. In some patients with dry lesions, the solution may increase dryness, scaling or itching. Where severe local infection or systemic infection exists, the use of systemic antibiotics should be considered, based on susceptibility testing. While topical steroids have not been reported to have an adverse effect on pregnancy, the safety of their use on pregnant females has not absolutely been established. Therefore, they should not be used extensively on pregnant patients, in large amounts, or for

prolonged periods of time. **Side Effects:** Side effects are uncommon with topical corticosteroids. As with all drugs, however, a few patients may react unfavorably to Synalar under certain conditions. In such cases the agent should be discontinued and appropriate measures taken.

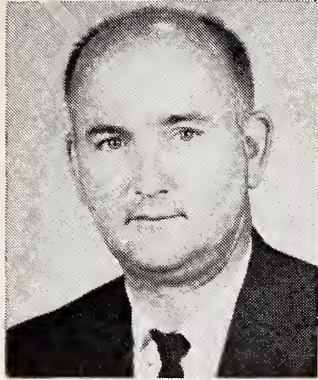
Availability: Synalar (fluocinolone acetonide) Cream 0.025%—5, 15 and 60 Gm. tubes and 425 Gm. jars. Cream 0.01%—15, 45 and 60 Gm. tubes and 120 Gm. jars. Solution 0.01%—20 and 60 cc. plastic squeeze bottles. Ointment 0.025%—15 and 60 Gm. tubes. Neo-Synalar® (neomycin sulfate 0.5% [0.35% neomycin base], fluocinolone acetonide 0.025%) Cream—5, 15 and 60 Gm. tubes.

fluocinolone acetonide—an original steroid from
SYNTEX 
 LABORATORIES INC., PALO ALTO, CALIF.

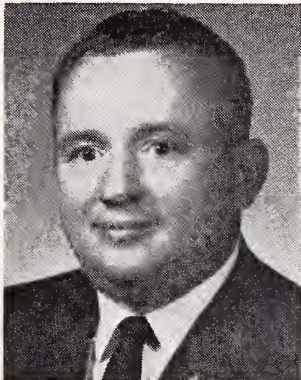


In Indiana

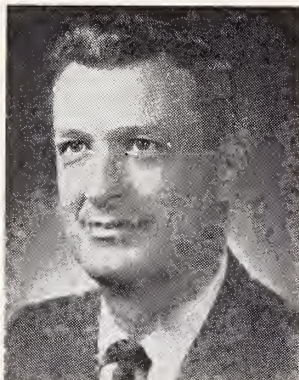
These Syntex men serve the physician . . .



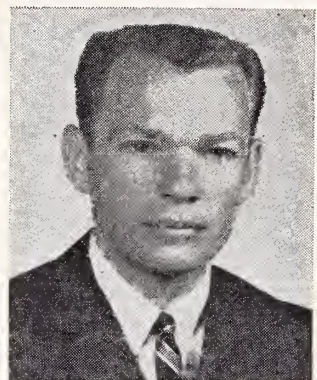
Edward Emerson
Cincinnati, Ohio
733-3292



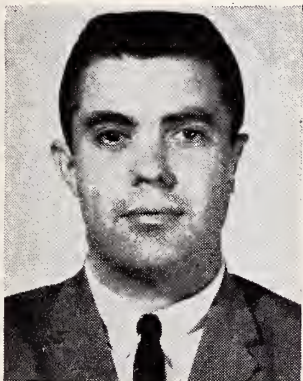
Harold Fleenor
Clarksville, Indiana
945-3032



Jerry Johnson
Elkhart, Indiana
264-0362



David Kraus
Louisville, Kentucky
776-6568



H. Spencer Stoner
Troy, Ohio
332-6579



John R. VanAman
Indianapolis, Indiana
846-3649

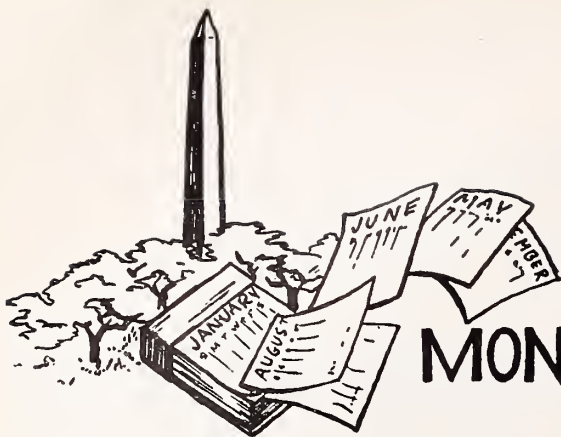


Howard Weinert
Chicago, Illinois
731-8327



Fremont Young
Brownsburg, Indiana
852-5919

SYNTEX 
LABORATORIES INC., PALO ALTO, CALIF.



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—The American Medical Association urged that Congress precisely define "public health services" to prevent the so-called "Partnership in Health" legislation being used as authority for unlimited expansion of government medicine.

IN A LETTER to Chairman Lister Hill (D.-Ala.) of the Senate Committee on Labor and Public Welfare, Dr. F. J. L. Blasingame, executive vice president of the AMA, said:

"WE ARE especially concerned with a lack of definition with respect to comprehensive public health services. Neither 'comprehensive' nor 'public health services' is defined in the law or the bill. While we recognize there is supportable advantage in removing strict categorization of grant funds, we are concerned that the categorical identification having been removed, there will no longer be any limitation on the health care which may be provided. Indeed, from testimony on this legislation by government officials, it would appear that our concern is justified. It is the intent that the Congress is authorizing a program of individual treatment for unidentified patients for unspecified conditions for unlimited services? It is clear that the lack of definition of 'public health services' is, in effect, an invitation from Congress to unlimited expansion of 'public health' beyond its traditional role in the community.

"THE AMA has supported, and continues to support the furnishing of public health services. We have also supported flexibility of operation within the state and local health departments as an effective tool for community health. We feel, however, that the distinction between the public and private health sectors should be delineated . . . in more positive terms that the mere prohibition against interference with the existing patterns of private professional practice Accordingly, the Association finds itself unable to support this portion of the legislation providing for an undefined program of comprehensive public health services."

THE AMA ALSO OPPOSED a provision for federal licensure of clinical laboratories on the ground that licensing of such facilities traditionally has been a state matter.

"WE BELIEVE that federal licensure of these facilities would establish an undesirable precedent," Dr. Blasingame said.

GENERIC VS. BRAND NAME DRUGS

THE CONTROVERSY over generic vs. brand name drugs was aired at hearings of the Senate Finance Committee and the Senate Small Business Monopoly Subcommittee.

CHAIRMAN Russell B. Long (D., La.) of the Finance Committee planned to offer an amendment to the Social Security bill, which includes medicare and medicaid changes, to put the emphasis on generic drugs in government medical programs. The monopoly subcommittee, headed by Sen. Gaylord Nelson (D., Wis.), was investigating drug pricing policies with the same objective as Long's proposal.

LONG'S PROPOSAL included the creation of a federal panel to select the highest quality but lowest cost prescription drugs for which patients would be reimbursed under government medical programs.

BOTH THE Food and Drug Administration and the drug industry opposed establishment of such a committee and national formulary of drugs.

FDA COMMISSIONER James Goddard, M.D., said it would result in "an encroachment on the practice of medicine in such a way that I believe the physicians of this country would rise up in wrath." He also said: "In essence the bill would impose upon the formulary committee the duty of evaluating every prescription drug used in medical practice today—more than 5,000—and of providing a formulary of the drugs of choice. I would have to exclude drugs deemed unnecessary, therapeutically duplicative, or of unacceptable quality. The enormity of such a task should be borne in mind."

C. JOSEPH STETLER, president of the Pharmaceutical Manufacturers Association, joined Goddard and John W. Gardner, Secretary of Health, Education and Welfare, in urging that action on the matter be postponed until a report is made on a special study being conducted by HEW. The report is due Dec. 1.

STETLER said the drug industry recognizes the government's responsibility to control federal expenditure in its drug purchase programs. But, he said, Long's proposal would put such a low ceiling on drug prices that it would "jeopardize the ability of quality, research-oriented pharmaceutical companies to perform effectively."

"THE HEALTH of all of us and of future generations is dependent on the continued growth and vitality of a progressive and successful pharmaceutical industry," he said.

ALCOHOLISM NEGLECTED HEALTH PROBLEM

NO OTHER national health problem has been so seriously neglected as alcoholism, according to John W. Gardner, Secretary of Health, Education and Welfare.

"THE ATMOSPHERE of moral disapproval surrounding the entire subject, and the deplorable custom of treating alcoholics as sinners or criminals have obscured the nature of the problem," Gardner said in connection with a report issued by the National Institute of Mental Health.

Continued

THE NIMH REPORT, titled "Alcohol and Alcoholism," reviews present knowledge of alcohol, the nature and extent of drinking problems; the identification, treatment and prevention of alcoholism, and the status of current research.

ALTHOUGH alcoholism obviously does not occur without alcohol, the report states that "alcohol can no more be considered the sole cause of alcoholism than marriage can be considered the sole cause of divorce, or the tubercle bacillus the sole cause of tuberculosis."

ON THE TREATMENT of alcoholism, the report says:

"In the past, alcoholics have been admonished, scolded, denounced, jailed, beaten, ducked, lashed, and threatened with eternal damnation. There is no evidence that any of these measures has had significant therapeutic value for more than an occasional alcoholic. Available evidence seems to demonstrate that long-lasting results can be achieved primarily by a technique known generally as psychotherapy."

MEDICARE INSURANCE RATE GOES UP

THE FEDERAL GOVERNMENT is planning on increasing the monthly medicare insurance rate for physicians' services for next year and 1969.

THE PRESENT RATE is \$3 a month. The medicare law designated Oct. 1 as the deadline for setting the rate for 1968 and 1969 but Congress approved legislation postponing the announcement until Dec. 31.

JOHN W. GARDNER, Secretary of Health, Education and Welfare disclosed a possible increase from \$3 to \$4 in a letter to Sen. John J. Williams, Del., ranking GOP member of the Senate Finance Committee.

THE MONTHLY PREMIUM is paid by persons 65 and older who elected to get benefits under Part B of the medicare program providing physician services.

"I WOULD promulgate a rate of \$3.80 for the two-year period of 1968 and 1969, 25 cents of the increase being based upon our evaluation of the extent to which we believe the premium rate was below the actual cost for 1966-67 and 55 cents being the estimated additional cost to be expected from an estimated increase in utilization and in physicians' fees," Gardner said. ◀



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?

in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
 (initial adult dose)

Indications: Urinary tract infections caused by gram-negative and some gram-positive organisms.

Side effects: Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

Precautions: As with all new drugs, blood and liver function tests are advisable during prolonged treatment. Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function. Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately 25 mg. per pound of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied: Buff-colored, scored Caplets® of 500 mg. for adults, conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000. 250 mg. for children, available in bottles of 56 and 1000.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

NegGram®
 Brand of
nalidixic acid
 a specific anti-gram-negative

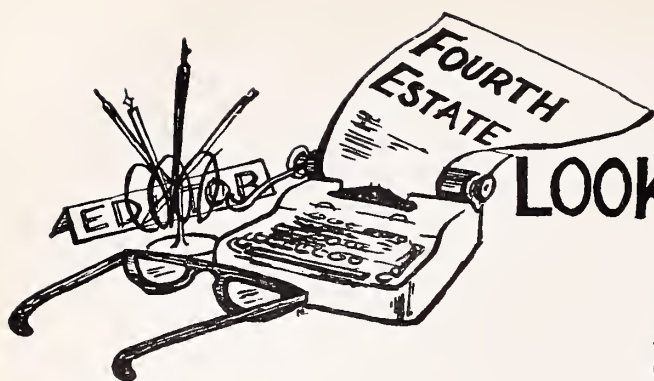
eradicates most urinary tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported in more than 2 out of 3 patients with either chronic or acute gram-negative infections.¹

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: *E. coli*, *Klebsiella*, *Aerobacter*, *Proteus*, *Paracolon* or *Pseudomonas*². However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Whither The Pharmacist?

We are puzzled by an aspect of the Medicare program brought to attention in the announcement of a new Indiana program to train graduate hospital pharmacists.

The Purdue University School of Pharmacy and the Indiana University School of Medicine will co-operate in the new program. It will include enrollment of graduate pharmacy students in courses previously restricted to medical students.

The demand for this new type of training was attributed to Medicare by Prof. Glen J. Sperandio, head of the Department of Clinical Pharmacy at Purdue.

"With the passage of the Medicare Act, the pharmacist has been mandated by the Federal government to supervise and control all aspects of drug distribution in the hospital and all extended-care facilities such as nursing homes," he said. "The pharmacist of the future must not only have the academic preparation for practice of pharmacy, but must be patient-oriented rather than product-oriented, and have first-hand knowledge of the patient's condition."

We can understand a desire for improvement in the control of drug distribution in hospitals. The delivery of correct medicines to individual patients in any sizeable institution is a formidably complicated and exacting operation. Tragic errors occasionally have occurred. It is certainly worth while to try to reduce the pos-

sibilities of error.

One such effort was announced recently by Eli Lilly & Company of Indianapolis. It is a new method of individual packaging of single dosages, designed for hospital use. The intent is that the capsule or tablet will remain in the package, bearing identification of the medicine, until the moment it is given to the patient. Thus both nurse and patient can know just what medicine is being taken.

We wonder, however, whether better control over the accuracy of administering prescribed medication is the objective of the Medicare mandate which Prof. Sperandio describes. The pharmacist should, of course, detect and question any significant variance from the usual prescription for a drug. His training is expected to make him competent to do this. But the professor seems to be describing a pharmacist who is trained to judge whether the right medicine has been prescribed for a given patient. This is the physician's responsibility.

The Medicare program already has been used as one peg on which to hang a renewal of congressional inquiry into the pricing of medicines with emphasis on the controversy about brand-name as opposed to generic drugs. This broadening of responsibilities could well draw the hospital pharmacist into the controversy.

Advancement in training for those who deal in the healing of the sick

always seems a good idea. We hope there is no shadow here of a move to interfere in the physician's control of medication for his patient.—*The Indianapolis Star*, Sept. 5, 1967.

Keeping Doctors At Home

An explanatory meeting was held at the Indiana University Medical Center today concerning a new plan which may encourage doctors to stay in Indiana.

The explanations were made to officials of 16 Indiana hospitals on the establishment of a new video tape educational network linking the Medical Center to selected community hospitals throughout the state.

The idea is to establish telecommunications facilities and internship-residency plans in selected communities and to follow up with a live television network. Future refinements will include high fidelity closed circuit television, teletype, facsimile reproduction and other electronic aids.

The program may be an effective answer to the increasingly serious problem of the exodus of doctors from Indiana. It is aimed at eliminating two important reasons why doctors go to other states.

One reason is that they like to practice in an area with which they have become familiar in their internship and residential training and the Indiana hospitals so far have had too few of these training opportunities to offer. The medical school graduates find them in other states and

consequently remain there.

Another reason is that doctors must keep abreast of the newest developments in the medical profession. This is frequently difficult in some communities where the facilities, equipment and personnel are not adequate.

The I.U. Medical Center is one of the great medical institutions of the nation. Through the new program, doctors will be given a close and constant link with the center and will have available all its vast resources.

The program is supported by funds provided by the last session of the legislature. It could make a substantial reduction in the 45% of medical graduates who leave the state each year. If so, it is of great value not only to the medical profession but to the entire state—*The Indianapolis News*, Sept. 14, 1967.

890 Med Students Turned Away

The full futility of Indiana's loss of hope for an early start on a second state medical school is brought home dramatically by the statistics for this year's freshman class at the Indiana School of Medicine.

The freshman class is the largest ever. It contains 221 students. That is an increase of five from last year's freshman class, which numbered 216. There were—and this is the shocker—another 890 applicants to the medical school who had to be turned down.

With the ratio of physicians to population going steadily in the wrong direction, that rejectee figure of would-be doctors is tragic.

Of the 890 rejectees, it is worth noting, nearly 600 were from out of the state of Indiana. Considering the volume of complaints last winter about Indiana-educated physicians who moved away from our state to practice, it strikes us that perhaps some of those 600 outsiders might see it here and stay—if we were equipped to give them a medical

education.

Had the plan passed by the 1967 General Assembly (creating a "blue ribbon" committee to pick a site for a second medical school) survived the governor's veto, there would still be only five more medical school freshmen in the state this year than there were last year, it is true. But we would have been as much as two years closer to the time when a second medical school would double the number of doctors in training in our state.

That target now has been shifted back toward the late '70s, and with every delay we are only increasing the odds that a medical crisis will be upon us before we are wise enough to act.—*South Bend Tribune*, Sept. 10, 1967.

More "Turn On"

Marijuana smoking among Indianapolis high school students is on the increase, according to Sgt. Kirby Crawley of the city police narcotics squad.

Writing about the local teen-age drug problem in his Tuesday column, David Mannweiler of *The News* said: "More and more 'nice' kids are exposed to it every year. And try it."

Mannweiler gave a number of reasons why a student would "turn on" with marijuana. "It's available. It's the 'thing to do' to prove you're cool. It's a means of rebellion. . . ." None of the reasons, he noted, has any merit.

What's worse than the fact that there is nothing "cool" about smoking marijuana is its bad effects on the user. In a strict medical sense marijuana is not "addictive," does not produce an irresistible craving. But, according to Mannweiler, 93% of the heroin addicts started their drug habits with marijuana.

Other dangers also exist in the use of marijuana. When a person is "turned on," he feels much as if he has been drinking, which makes him a threat to himself and others, espe-

cially if he drives while under the influence.

The use of marijuana is perhaps not inevitable, but certainly predictable, in a permissive environment. The "kicks" seeker who tries marijuana and graduates to heroin can all too easily turn to crime to pay for the habit and may possibly die a premature, painful death.—*The Indianapolis News*, Sept. 14, 1967.

Hospitalization Cost

The local practice of having surgery patients admitted to the hospital several days prior to the scheduled operation may be largely eliminated.

Blue Cross-Blue Shield has announced the adoption of an administrative policy that should appeal to both the patients and the company.

In short, whenever pre-surgical tests can be conducted on an outpatient basis, the insurance company will now approve payment for those tests which directly apply to preparation for surgery.

The new policy should reduce the cost of hospital stay, allow the patient to spend less time in the hospital and relieve bed shortages in hospitals.

The new plan has received the endorsement of the Indiana State Medical Association, Indiana Hospital Association and the Indiana Department of Insurance.

If it makes any difference to them, it also has the endorsement of *The Mt. Vernon Democrat*. — *Mt. Vernon Democrat*, Aug. 16, 1967.

Two Medical Schools

The persistent shortage of physicians in this country lends unusual interest to the opening of any new medical school. That applies to the University of Arizona Medical School, whose first class of 32 men and women will convene this fall. The occasion is given a special filip by the fact that it coincides with celebration of the 200th anniversary of the founding of the Columbia University College of Physicians and Sur-

FOURTH ESTATE

Continued

geons, which as King's College awarded the first M.D. degrees in America.

This country's first medical school was founded in 1765 at what was to become the University of Pennsylvania. It was the progenitor of the Columbia school in New York City, however, which opened in November 1767, that granted the first two M.D. degrees on this side of the Atlantic.

Since then, the primitive medical practice of Colonial America has been transformed and medical education in this country has become the world's finest. Columbia's College of Physicians and Surgeons has played a generative role in this transformation, and deserves the high honor it will be accorded in October when a worldwide symposium on "Genetics and Development" will be held to observe the school's bicentennial. That will be an important occasion in the history of American medicine.

And so, in its way, will be the concurrent opening of a new medical school at the University of Arizona. The best we can wish for it is that it will carry on in the fine tradition established two centuries ago at Columbia. — *Terre Haute Tribune*, Aug. 19, 1967. ◀

Digitalis—Would FDA Approve It Today?

"... I would hate to be introducing digitalis as a new drug today. Anyone reading the toxicity and side effects would never use it in the present climate. However, digitalis has been with us long enough now that the toxicity and side effects have taken their proper place. They are there, to be sure, but not as prominently as the therapeutic effect. — Robert W. Ballard, M.D., in *Food Drug Cosmetic Law Journal*, (21:31-32), January, 1966.

Who Controls 'Quality Control

Much is made of quality control for brand-named drugs. The question is who will control the quality if on the generic name is used? The government? Not likely, in view of the many problems it already cannot solve.

If the government had to exercise quality control over all generic labeled drugs, this would be a fabulously expensive and time-consuming operation. Certainly neither the physician nor the consumer can do it. For some drugs, control is not very necessary, but there are too many for which it is essential and there is no easy way to separate the two groups. — Irvine H. Page, M.D. in *Modern Medicine*, (34:105), June 6, 1966.

A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

W. R. VanDenBosch, M.D.

David L. Evans, M.D.

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

J. Kenneth Cooke, M.D.

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

(Phone)

447-6404

447-9155

743-1809

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

The
AMBAR
SCRAPBOOK
of

Obesity Oddities

FACT & LEGEND

CHARLES DICKENS' "FAT BOY JOE" in Pickwick Papers

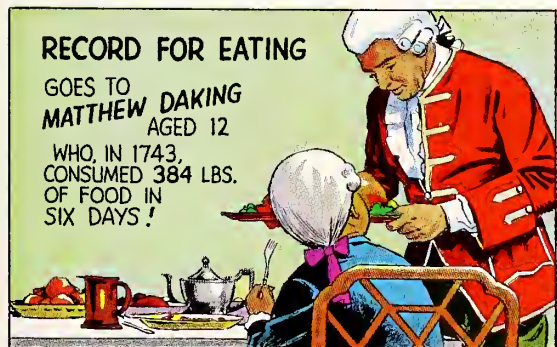
IS THE FIRST RECORDED CASE OF
OBESITY WITH NARCOLEPSY
DR. C. SIDNEY BURWELL COINED THE
TERM "PICKWICKIAN SYNDROME" IN 1955!



Obese Epitaph
in English graveyard

RECORD FOR EATING

GOES TO
MATTHEW DAKING
AGED 12
WHO, IN 1743,
CONSUMED 384 LBS.
OF FOOD IN
SIX DAYS!



THE Cost of AMBAR EXTENTABS

IS APPROXIMATELY
ONE-HALF THAT OF
OTHER LEADING
APPETITE
SUPPRESSANTS.



AN IMPORTANT FACTOR
IN LONG-TERM THERAPY!

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A-H ROBINS

**"Breathing's
a snap again,"
he said
gingerly.**

(COMPLIMENTS OF
DIMETAPP)



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis. **Contraindications:** Hypersensitivity to antihistamines. Not recommended for use during pregnancy. **Precautions:** Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care

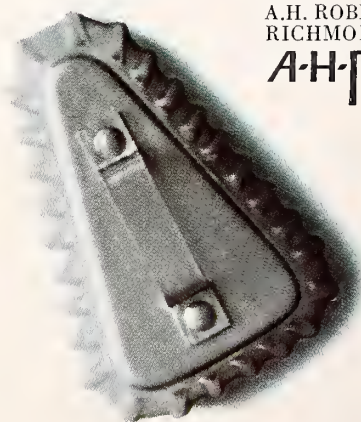
to patients with cardiac or peripheral vascular diseases or hypertension. **Side Effects:** Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered. **Dosage:** 1 Extentab morning and evening. **Supplied:** Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220
A-H ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.;
phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear
breathing on one tablet



What's New?

Flint Laboratory technicians determined serum cholesterol levels on nearly 800 doctors at the recent AMA meeting by using the Unitest System manufactured by Bio-Dynamics, Inc., of Indianapolis. The method gives accurate findings in less than seven minutes with only one minute of actual working time. The Unitest System is also used to measure other blood chemistries such as true glucose, B.U.N., hemoglobin, uric acid and bilirubin. It was developed for use in doctors' office laboratories but it is now being used in nursing homes, hospitals and independent laboratories.

* * *

Chest massage and mouth-to-mouth resuscitation by manual technic are the first steps in treatment of cardiac arrest. Corbin-Farnsworth, a medical electronics subsidiary of Smith Kline & French, is introducing a lightweight compressor and ventilator which may be moved quickly to the patient for continued resuscitation. Called the Cardio₂ External Cardiac Compressor with Synchronized Ventilator, the device is powered by compressed gas, accurately times and proportions its actions and may be adjusted so that the chest compression force is measured and consistent. It is explosion proof and is insulated to permit defibrillation while in use.

* * *

Riker Laboratories is introducing a new urinary tract anti-bacterial agent—Hiprex (methenamine hippurate). It has proven to be highly effective against a broad spectrum of urinary tract pathogens, and is particularly useful in difficult-to-treat infections caused by specific strains of bacteria. The usual dose is one tablet twice daily.

* * *

Philips Roxane Laboratories are joining 14 major independent drug wholesalers in the formation of a new company for the manufacturing and distribution of assured quality generic pharmaceuticals. Philips Roxane will provide the manufacturing facility. Kiefer-Stewart of Indianapolis is one of the companies represented in the entity which will be called Alliance Laboratories.

* * *

Syntex is packaging Synalar (fluocinolone acetate) in 60 gram tubes for economy and convenience during prolonged therapy. Four dosage forms will be involved—Synalar cream 0.01 percent, Synalar cream 0.025 percent, Neo-Synalar cream and Synalar ointment.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



One by one the family's downed Because the G.I. bug's around

Parepectolin for quick relief of acute diarrhea
... soothes colicky pain with paregoric*
... consolidates fluid stools with pectin
... adsorbs irritants with kaolin,
and protects intestinal mucosa

Whether it's a 24-hour "bug", a food problem, or simply nervousness and anxiety, Parepectolin will bring the diarrhea under control until etiology can be determined. In some cases, Parepectolin may be all the therapy necessary.



Parepectolin[®]

Each fluid ounce of creamy white suspension contains:

*Paregoric (equivalent) (1.0 dram) 3.7 ml.
Contains opium ($\frac{1}{4}$ grain) 15 mg. per fluid ounce.

warning: may be habit forming

Pectin (2½ grains) 162 mg.
Kaolin (specially purified) (85 grains) 5.5 Gm.
(alcohol 0.69%)

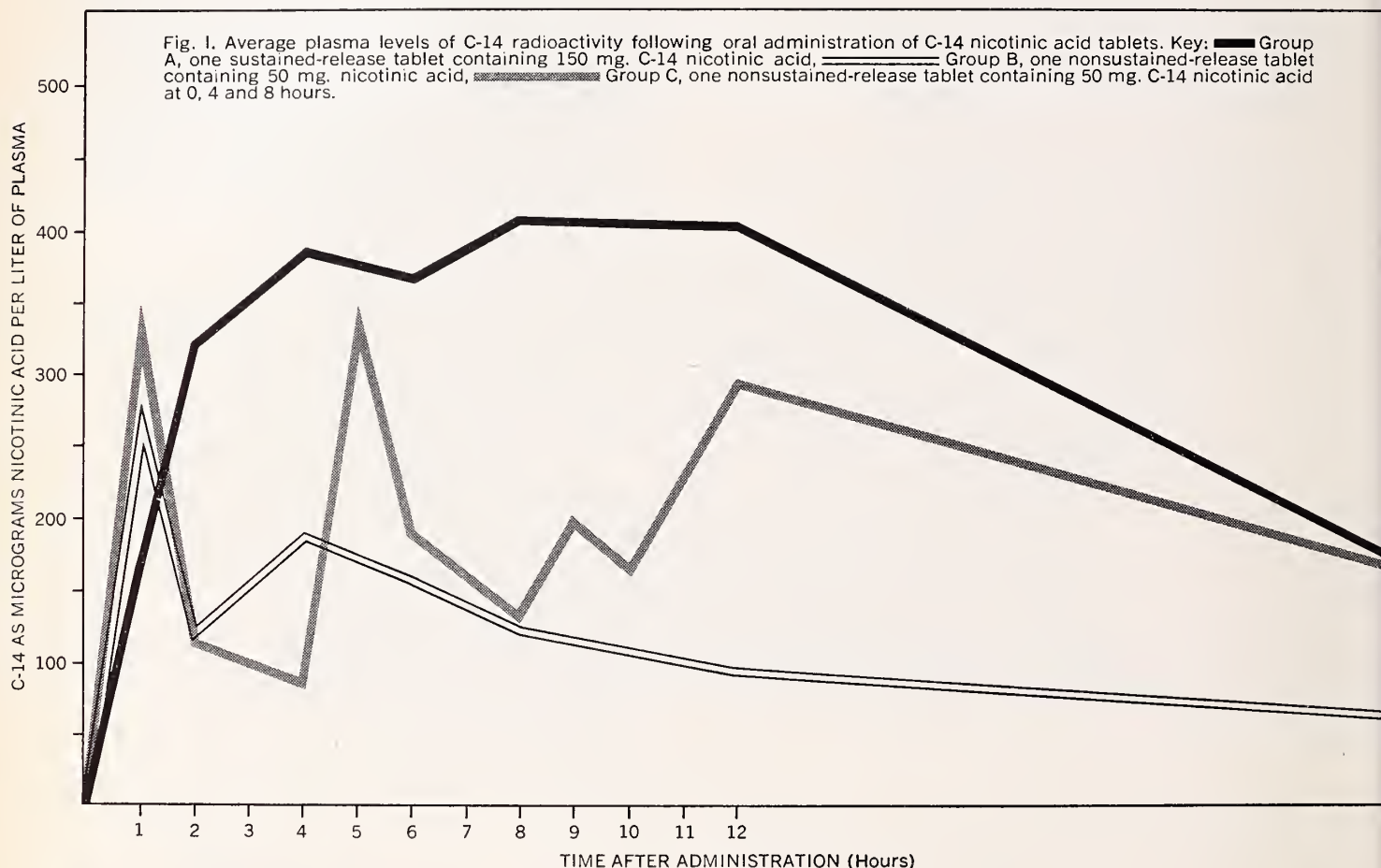
Usual Adult Dose: One or two tablespoonfuls three times daily.

Usual Children's Dose: One or two teaspoonfuls three times daily.



WILLIAM H. RORER, INC.
Fort Washington, Pa.

Sustained circulatory, respiratory and cerebral stimulation for the



(fewer absent doses by
absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

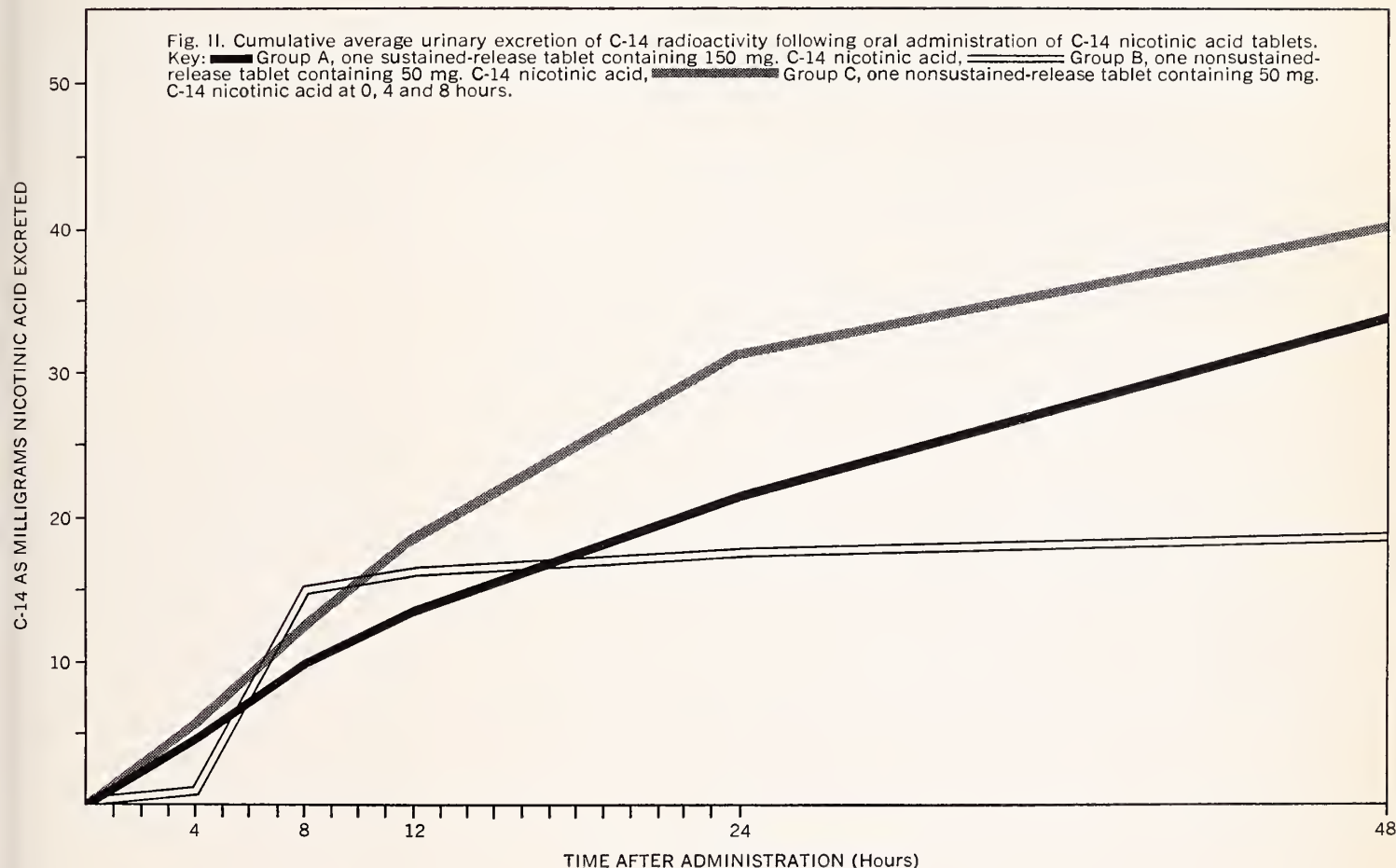
Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-

mindedness or senile confusion. Therapy *can* be continuous on a daily dose of only one Geroniazol TT tablet every 12 hours.

The gradual release of nicotinic acid in Geroniazol TT will provide the well-known peripheral vasodilation needed in patients with deficient circulation and with a minimum amount (if any) of "flushing." Also, cerebrovascular circulation is complemented by pentylentetrazol, long-established as a cerebral and respiratory stimulant.

Geroniazol TT improves the typical, unfortunate, signs of senile confusion. Patients become more alert,

ged and debilitated



less confused and moody. Personal care, memory, emotional stability, social attention improve. Fatigue, apathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will permit your patients to enjoy the benefits of time-prolonged nicotinic acid/pentylenetetrazol therapy, at an economical price. Dosage is only one tablet every 12 hours.

Contraindications: There are no known contraindications.

Precautions: Exercise caution when treating patients with a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. 56:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. 11:617 (July) 1960.



"First with the Retro-Steroids"

PHILIPS ROXANE LABORATORIES

Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol[®] TT

nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol[®] Time Controlled Tablet

Letters

to the editor

To the Editor:

On Sunday, Sept. 10th, I attended a meeting in Indianapolis sponsored by AMPAC and its subsidiary organizations. The speakers were very learned and sage persons far more knowledgeable than I in current political practices. But these credentials alone do not qualify them for a portion of my hard-earned and difficult-to-keep income to support the organizations they represent. Among the speakers was none other than the golden-tongued Dr. Edward R. Annis, whose sage advice is always welcome to this observer. Another very dedicated conservative Democrat physician from New York spoke on a subject entitled, "Why Me?"

While listening to his comments, I seriously asked myself "Why Not Me?" After summing up the day's events I believe I can honestly answer this question and I pass this on to other physicians. I sincerely wish that our leaders in I-HOPE and AMPAC will seriously consider these comments in the light in which they are intended. I have said many times that the leadership in organized medicine has been looking only ahead of them at the enemy, not bothering to see how many of their "mighty warriors" behind them have fallen by the wayside—some have defected, some have been wounded and some have died of political attrition. It's high time our "generals" looked around them and make some tactical changes in order to "beef up" their army lest we all be captured by our socialist enemy. But as yet they piously bemoan their sad plight by asserting the stupidity of us "oafs" in not obeying their blind commands.

While I am definitely not (nor ever intend to be) politically expedient for expediency's sake, neither am

I politically naive. It is utter folly to support "the lesser of two evils" as AMPAC and I-HOPE have been doing in some instances. This is merely driving the nail in our own coffin—slower but just as certain. The cost of this illogical venture may be only a few thousand dollars this campaign, but what will it cost the Illinois physicians, for instance, the next campaign to buy Charles Percy when he bargains with his true friends on the socialist left? Until I have some assurance that conservative or constitutional candidates *alone* will be financially supported, I shan't contribute one dime toward my own destruction.

Until this time comes, I will gladly support directly any candidate in whom I have faith will support the only item which has given this country its great heritage—the U. S. Constitution. Unfortunately, recently, I haven't even been given this opportunity. Why? Naturally, it's just not "politically expedient" in today's contemporary politics. I'm convinced that "political expediency" is rapidly destroying this great country and I'm not going to be a party to it. A true conservative, by definition, doesn't have to be bought. He merely needs our support to get him elected. This is not so with a "less socialistic socialist." His price will continue to escalate and this is political bribery.

I also take exception to Congressman Burlinson's remark to the effect "Give me a conservative Congress and they can have the White House." Today our Congress is merely a massive display of puppets being manipulated by our White House-appointed Supreme Court and Cabinet members. If the puppets perform "correctly" they are rewarded; if they perform "badly", the "bad" performances are merely eliminated by our loaded Supreme Court which has truly raped our great Constitution. It appears that the Congressman from Texas is a bit politically naive

when he thinks our Congress is so powerful today. This might have been true in the pre-Roosevelt era but this is 1967 and our executive and judicial branches of government greatly overshadow the token force our legislative branch plays in our government.

So let's reconsider the battle we are fighting and ask ourselves if we haven't been truly aiding our own enemy. Let's have some leadership which speaks out publicly and unequivocally for the capitalistic free enterprise system with no apologies and we will settle for *nothing less* than adamant Constitutional Government. Until then, this is "Why Not Me?"

Lloyd L. Hill, M.D.
Peru, Indiana

To the Editor:

We are engaged in a Doctor-to-Doctor Program whereby the physicians of the U.S.A. are being asked to send their current medical journal—after they have read them—to colleagues overseas, particularly in Asia, Africa and Latin America.

This program has two functions: first, to provide *current* medical literature to overseas physicians who cannot obtain it otherwise and second, to open up avenues of communication between all physicians and their overseas colleagues establishing thereby a basic medium for better understanding.

We obtain the names of these overseas colleagues and their specialties in various ways—from secretaries of the national medical associations of their countries, from institutions, U.S. State Department personnel and from many other sources.

At present we have more requests from these overseas physicians for journals, particularly in the specialties, than we are able to supply. Would it be possible to have an announcement about our program published in your journal?

We will greatly appreciate an

assistance you may be able to give
is in this undertaking.

Ada Chree Reid, M.D.
Director,
Doctor-to-Doctor Program

The Power of the FDA

. . . The medical profession as a whole and the American Medical Association in particular have expended a great deal of . . . time and energy in an unsuccessful fight against medicine. The banner under which this battle was fought was "We Oppose Socialized Medicine."

I believe it is fair to say that this battle was fought to prevent further inroads by the government into the financing of the practice of medicine.

While this one battle progressed leisurely to its conclusion, the government (primarily the Food and Drug Administration) quietly stole the march on the medical profession in a much more important battle that may be won without a shot being fired. I refer not to government participation in the financing of medical treatment but rather government dictatorship over all aspects of medical treatment itself.

While few were watching, and few were caring, the Food and Drug Administration has vastly expanded its powers and duties.

More and more it tells the physician how he is to practice his art.

More and more it tells the pharmaceutical manufacturers how to run their highly complex industry in each and every detail . . .

There are a few in Congress, like Congressman Fountain and me, who have viewed this process . . . if you will pardon the expression . . . with a jaundiced eye. I, for one, believe it is time for the medical profession as a whole to carefully review how far it is willing to have the government interfere in the practice of medicine. This is equally as important as government's role in the financing of medical care.

Once the harm is done, it will be impossible to undo.

The process whereby medical judgment is slipping from the hands of the profession into the hands of the bureaucrats is both fast and silent.

Is this process inexorable?

Only the doctors of the nation can supply the answer. As a profession, they should see that Congress tames the FDA before it absorbs what remains of medical freedom.

Sen. Edward V. Long (Mo.)
Chairman, Subcommittee on Administrative Practice and Procedure.
—Reprinted from *The AMA News*,
Volume 10, No. 32, August 7, 1967.
Reprinted with permission. ◀

Statement of ownership, management and circulation (Act of October 23, 1962; Section 4369, Title 39, United States Code)

1. Date of filing: September 21, 1967.
2. Title of Publication: THE JOURNAL of the Indiana State Medical Association.
3. Frequency of issue: Monthly.
4. Location of known office of publication: 3935 N. Meridian St., Indianapolis, Indiana 46208.
5. Location of the headquarters or general business offices of the publishers: 3935 N. Meridian St., Indianapolis, Indiana 46208.
6. Names and addresses of publisher, editor, and managing editor: Publisher, The Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Indiana 46208. Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis, Indiana, Editor.
7. Owner (If owned by a corporation, its name and address must be stated and also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given); Indiana State Medical Association, Indianapolis, Indiana 46208.
8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None.

9. Paragraphs 7 and 8 include, in cases where the stockholder or security holder appears upon the books of the company as trustee or in any other fiduciary relation, the name of the person or corporation for whom such trustee is acting, also the statements in the two paragraphs show the affiant's full knowledge and belief as to the circumstances and conditions under which stockholders and security holders who do not appear upon the books of the company as trustees, hold stock and securities in a capacity other than that of a bona fide owner. Names and addresses of individuals who are stockholders of a corporation which itself is a stockholder or holder of bonds, mortgages or their securities of the publishing corporation have been included in paragraphs 7 and 8 when the interests of such individuals are equivalent to 1 percent or more of the total amount of the stock or securities of the publishing corporation.

10. The average No. of copies each issue during preceding 12 months are: (A) Total No. copies printed 4,900 (net press run). (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, 100. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, 150. (E) Total distribution (sum of C and D), 4,650. (F) Office use, leftover, unaccounted, spoiled after printing, 250. (G) Total (sum of E & F—should equal net press run shown in A), 4,900. No. of copies single issue nearest to filing date are (A) Total No. copies printed (net press run), 4,900. (B) Paid circulation: 1. Sales through dealers and carriers, street vendors and counter sales, 4,400. 2. Mail subscriptions, 100. (C) Total paid circulation, 4,500. (D) Free distribution (including samples) by mail, carrier or other means, 200. (E) Total distribution (sum of C and D), 4,700. (F) Office use leftover, unaccounted, spoiled after printing, 200. (G) Total (sum of E & F—should equal net press run shown in A), 4,900.

I certify that the statements made by me above are correct and complete.

James A. Waggener
Business Manager

INDIANA MEDICAL BUREAU

816 Hume Mansur Bldg.

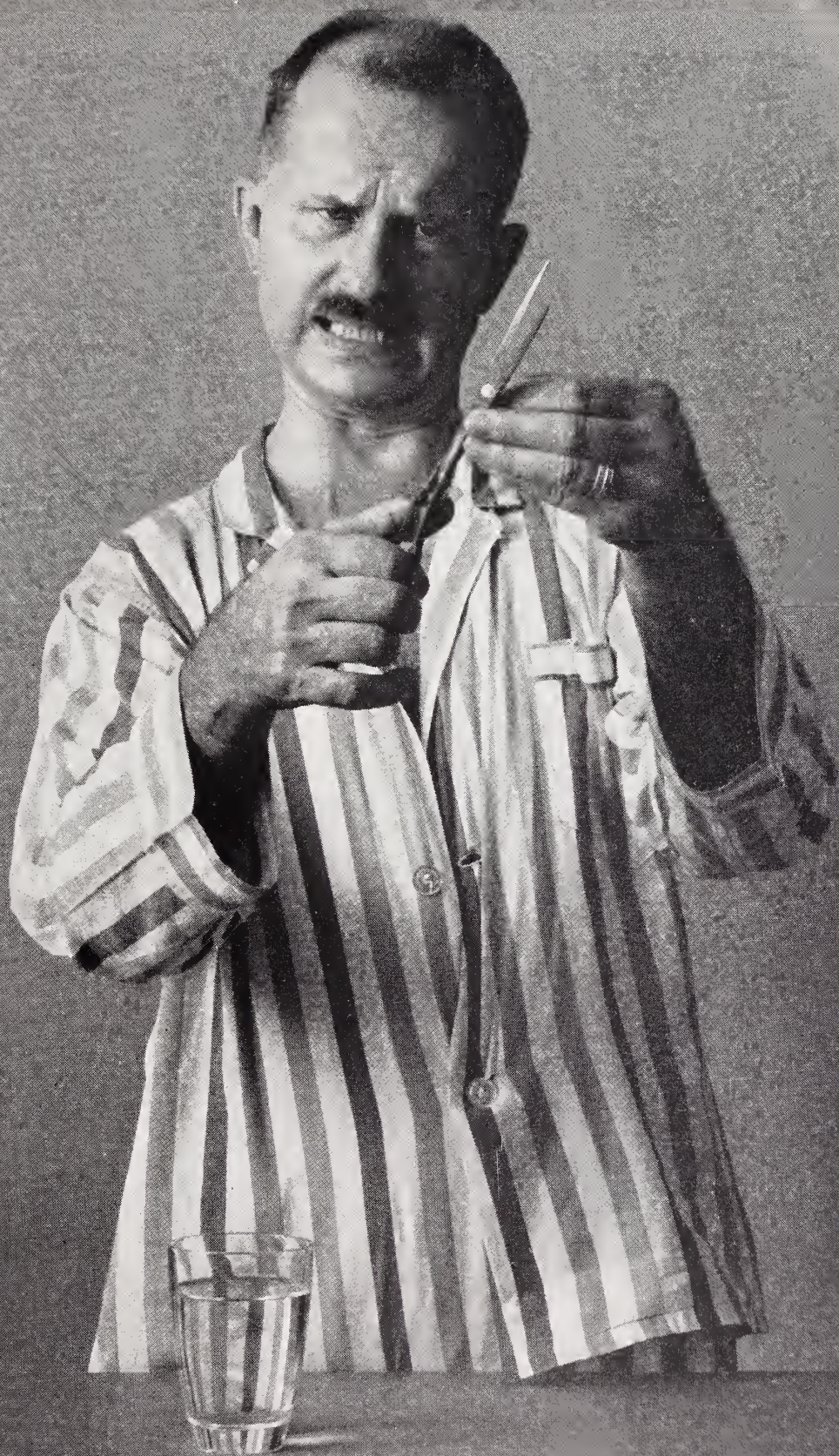
634-5804

A Licensed Employment Agency
Specializing in Medical Personnel

Our 16th Year Of Service



Maybe you don't want
your patients to halve Hygroton®chlorthalidone.



Maybe your patients complain:
"Why don't they make a tablet I don't have to halve?"

Please see brief prescribing summary at the end of advertisement.



Maybe you abandoned Hygroton^{chlorthalidone} because there wasn't a convenient half strength.

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warnings: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients, since the drug may cross the placental barrier and cause adverse reactions which may occur in the fetus (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential problems in the newborn.

Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and patients receiving ganglionic blocking agents or other potent antihypertensive drugs. Urinary. Reduce dosage of concomitant antihypertensive agents by at least one-half. Salicylates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Exercise special care in cirrhosis or severe congestive heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Sodium restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramp-dizziness, weakness, restlessness, hypoglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, granulocytosis, impotence, dysuria, transient edema, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis. Epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Usual Dosage: One tablet with breakfast or every other day.

Stability: White, single-scored tablets of 50 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B)46-230-D

For full details, please see the complete prescribing information.

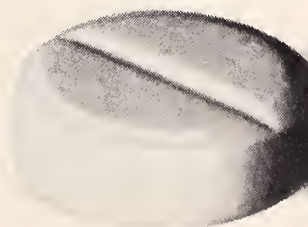
Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Basis, New York

Here's the Hygroton they don't have to halve



New Hygroton 50 mg. from Geigy

to go with the Hygroton 100 mg. you know



When the agitated geriatric disrupts the home...

His teen-age
granddaughter
won't invite
friends
home
because
of his
outbursts.



for moderate to severe anxiety

Mellaril[®]
(thioridazine)

25 mg. t.i.d.



**His slovenly room
and habits create
more tension.**

**His disturbances at
the table make every
meal a nightmare.**

**His daughter
can't please him.
There is "just no
living with him."**

When the agitated geriatric disrupts the home...

Anxiety that seriously interferes with the individual's performance at work, at home, or in the community may be regarded as moderate to severe in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide.....195 mg.
Aminophylline.....130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl.....16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



**Pick one to die.
Pick one for jail.
Pick one to waste away.
Pick three for happiness.**



Some children find happiness easily. Others need the help and guidance only a trained person can provide, medical attention they cannot afford, love they have been denied. When you decide to give to your United Fund or Community Chest, you may change a life.

Your fair share gift works many wonders/THE UNITED WAY



easy does it!

tear, moisten, compare—that's all!



Introduction to this special issue on the programs of the Krannert Institute.

The Krannert Institute of Cardiology

THE KRANNERT Institute of Cardiology was founded by Herman C. Krannert and his wife, Ellnora D. Krannert in 1963, as a product of their continuing interest in supporting medical research.

The Krannert Institute of Cardiology climaxes a heart disease program which was initiated immediately following World War I at the Marion County General Hospital, then known as Indianapolis City Hospital. Through the untiring efforts of Drs. Robert M. Moore, Cyrus J. Clark and Kenneth G. Kohlstaedt, the first cardiology clinic was established to serve the citizens of the community. Early encouragement to expand this much-needed program came from Mr. and Mrs. Krannert with the establishment of the first cardiology fellowship and the addition of the technical personnel and equipment.



In 1952, Mr. and Mrs. Krannert formally established the Robert M. Moore Heart Clinic, the purpose of which was to offer cardiological care to the needy of Marion County, to teach medical students, house staff and fellows and to conduct research. The program expanded to include more research activity and because of its multifaceted orientation, proved highly successful in attracting postgraduate trainees in cardiology.

The success of the program was in large measure assured by the co-operation of the administration of the Marion County General Hospital headed by Dr. A. G. Popplewell, by the interest of Dr. B. L. Martz and Dr. K. G. Kohlstaedt of Lilly Laboratories for Clinical Research and by the academic, scientific and financial support of Dr. John B. Hickam, Chairman of the Department of Medicine, Indiana University School of Medicine. The scientific and academic integration with the Department of Medicine proved so successful that the Krannert Institute, Division of Cardiology of the Department of Medicine and the Clinical Cardiology Service of the Marion County General Hospital which includes the Robert M. Moore Heart Clinic have become a single functioning unit; a union which has proven most beneficial to the development of cardiology in Indiana.

The major investigative interests of the Institute are in the areas of electrophysiology, myocardial metabolism and coronary artery disease. The various laboratories of the Institute described in this issue by the individual investigators have been established with these general interests in mind.

Each year an average of five to seven United States Public Health Service post-doctoral trainees of the Department of Medicine receive cardiovascular training in the laboratories and the clinics of the Institute.

Because of the generous support of the Krannerts, the Institute has its own home and the laboratories are fully equipped with modern, sophisticated equipment. Such basic facilities made it possible to attract a highly skilled professional staff capable of supporting their individual laboratories with grants from such outside agencies as the Public Health Service, Heart Association and the American Medical Association Committee on Research and Education.

CHARLES FISCH, M.D.
Director



High Fidelity Electrocardiography

GARY J. ANDERSON, M.D.

IN 1917 Rothchild and Oppenheimer¹ first suggested that the notched electrocardiogram was indicative of cardiac abnormalities. These notches were not further studied until Langner^{2,3} in 1952 developed specialized equipment to take the high-fidelity electrocardiogram (HFE). As opposed to the conventional electrocardiogram (ECG), the HFE is capable of recognizing abnormalities produced by the electrical activity of the heart beat. This is accomplished by recording at a very fast rate, thus expanding the QRS complex to several centimeters wide and also by increasing the sensitivity of the instrument, so that it is several times that of the normal electrocardiogram. In addition to this, the information is fed into a special circuit which is capable of detecting the fine abnormal notches and slurs, and this is recorded in what is termed as the first derivative. (The first derivative may be defined as the rapidity or rate of change of the ECG curve. Large peaks, notches and slurs in the ECG are reflected by large changes in the derivative.) Exam-

ples of notching and slurring and their effects on the first derivative may be noted in Figure 1 and 2.

The conventional twelve leads are taken as well as the para-orthogonal leads X and Y. After amplification and derivation, the data is recorded on a storage oscilloscope and photographed on polaroid film for analyses. The basic differences between the conventional and high frequency ECG are illustrated in Table 1.

Leads Analyzed Separately

Since the HFE primarily studies changes in intraventricular conduction and the terminal specialized conduction systems, only QRS phenomena are studied. The primary changes observed indicative of high frequency components are notches and slurs. The changes are defined in terms of the derivative (Figure 1). The latter is defined as any condition where the derivative passes through zero. (Figure 2). Each lead is analyzed separately both in terms of the numbers of notches and slurs and their position in the QRS complex. Notching and slurring are un-

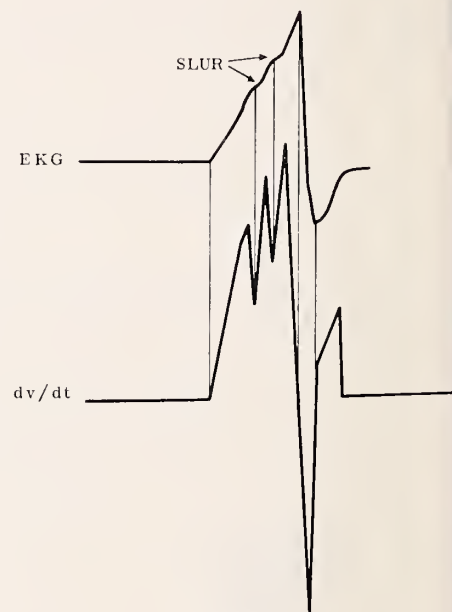


FIGURE 1

DIAGRAM of fine slurring on the upstroke of the R wave of the conventional ECG, with concurrent changes in direction of the first derivative (dv/dt). Note that since the first derivative does not return to, or pass through the baseline, it defines slurring in the ECG.

common in leads I, II, AVF and the lateral precordial leads, especially on the descending limb of the QRS complex. On the other hand, notching is relatively common in leads III, V₁ and V₂.

In the normal high frequency electrocardiogram (Figure 3) the QRS complexes are generally free of notching, especially leads I and II, and the downstroke and S of precordial leads V₃ through V₆. The first derivative does not show any evidence of abnormal high frequency components. The normal lateral precordial leads generally have one or no notches on the downstroke of the R wave, and, when excessive notching or slurring does occur, the probability of such a tracing being nor-

	STANDARD EKG	HFE
Frequency Response	0.1→80-140 cps	.005→2000 cps
Analysis	Entire EKG Gross Configuration	QRS only Fine Slurring and Notching
Accessory Tools	None	First Derivative Frequency Spectrum Analyzer Digital Computers
Paper Speed	25, 50 mm/sec	10→20,000 mm/sec
Amplification	1 mv = 1/2→2 cm	1 mv = .5 mm→100 cm
Method of Recording	Paper	Recording Tape Polaroid Film

TABLE 1
COMPARISON of the conventional and high frequency electrocardiogram.

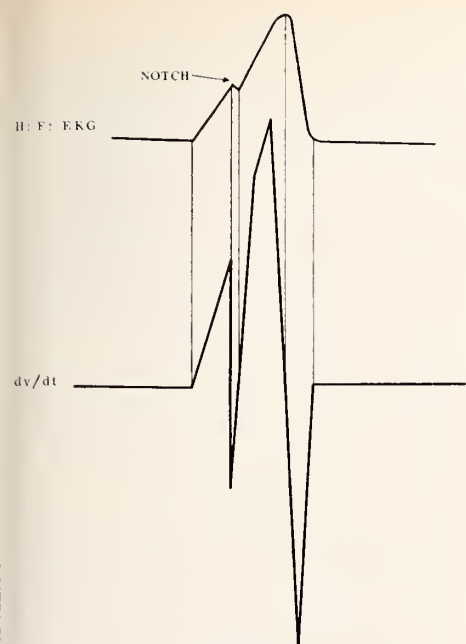


FIGURE 2

A NOTCH on the upstroke of the R wave (upper trace) produces a deflection through the zero point (baseline) of the first derivative, and hence defines notching in the ECG.

mal is less than one percent.

The application of high frequency electrocardiography in ischemic heart disease is presently being studied by a number of investigators. Recently, Boyle, Carson and Hamer⁴ reported increased numbers of high frequency components in patients with ischemic heart disease. Of these patients who had normal conventional ECG's, 60% demonstrated abnormal HFE. In addition, increasing severity of HFE changes were observed in those groups of patients having an abnormal ECG and/or positive Master's tests. While the HFE changes observed in ischemic heart disease are not known to be specific, the HFE technic lends itself readily to the early diagnosis and differentiation of functional problems from organic heart disease. Furthermore, studies by Langner⁵ in the area of myocardial infarction have shown that induced myocardial infarction in dogs without the development of an abnormal Q wave was associated with abnormalities in the HFE. Clinical correlations have shown that humans several years post-infarction may not

FIGURE 3
NORMAL HFE. Note the relative absence of high frequency components, especially in leads I, II, and the downstroke of the lateral precordial leads. In the first derivative there is always some interference and this should not be mistaken for notching or slurring.

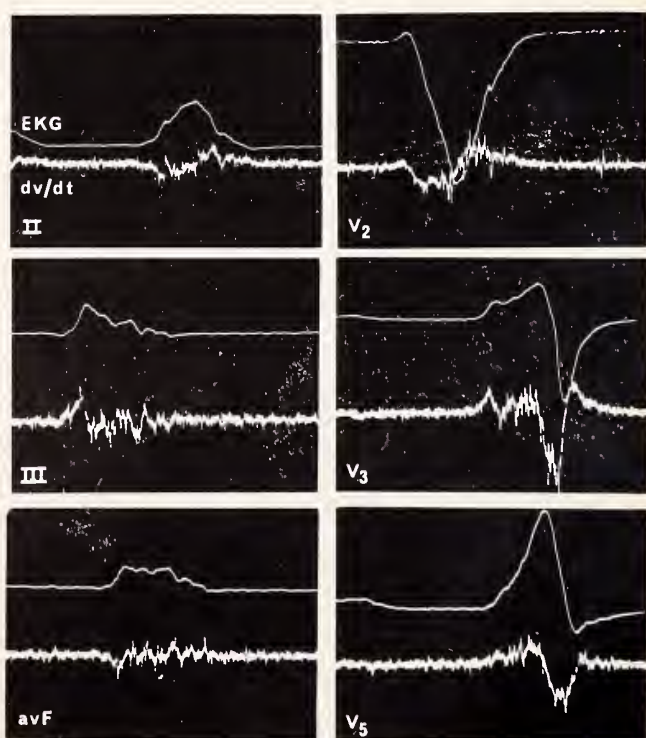
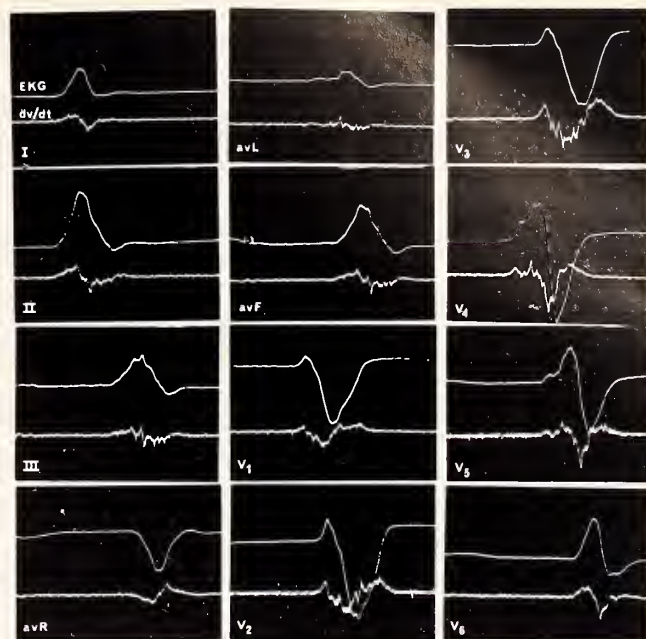


FIGURE 4
NOTE the fine slurring and fragmentation of the QRS in leads II, III, AVF, and upstroke of V₃ and V₅. This is compatible with diffuse myocardial disease.

reveal any ECG evidence of infarction (e.g., abnormal Q wave), yet the HFE remains abnormal (i.e., displaying notches and/or slurring). Such studies would indicate that HFE may prove to be a considerable advance in the detection of coronary artery disease, especially when the conventional ECG is normal, or shows non-specific ST-T wave changes, without QRS pattern alteration.

The Cardiomyopathies

The diagnosis of non-coronary disease of the heart, excepting the valvular diseases, or the so-called cardiomyopathies, have remained a diagnostic problem. Such patients frequently present with congestive heart failure alone, and may present with typical angina such as in Friedreich's ataxia. Not infrequently the diagnosis of cardiomyopathy is one of exclusion, or at best compatible with the disease process known to involve the myocardium, (e.g., scleroderma or amyloidosis). Recent studies by Anderson et al.⁶ and substantiated by Reynolds et al.⁷ reveal that the cardiomyopathies generally produce more extensive changes in the HFE than the coronary artery disease group.

Figure 4 shows a tracing on a 39-year-old Negro male who presented with historical evidence of biventricular failure. However, he denied any evidence of chest pain and there was no history or physical findings compatible with rheumatic valvular disease. The HFE showed diffuse notching and slurring in leads II, III, AVF and fine notching of the

upstroke of V₃, and this was felt to be compatible with a cardiomyopathy. Subsequent historical work revealed that the patient had ingested 1-2 pints of whiskey per day for at least 15 years, a fact strongly favoring the diagnosis of alcoholic cardiomyopathy. At present, the cardiomyopathies cannot be readily differentiated from each other. Unpublished observations by the author suggest that various cardiomyopathies may be distinguishable from each other by analysis of the frequency of the notchings. It is of interest that coronary artery disease has been shown to produce three frequency bands.⁸

At present, studies are being undertaken in both coronary and non-coronary artery disease. In the coronary disease groups patients will be evaluated periodically with the HFE as well as frequent serial tracings post-infarction to study the evolution of conduction defects. Patients with angina without myocardial infarction will also be followed to determine the possible correlation between increasing severity of angina and changes in the HFE. In the non-coronary artery disease group, most forms of cardiomyopathy are being investigated. Since this group of patients usually shows more severe changes with higher frequency components than the coronary artery disease group, its clinical usefulness is being utilized.

The application of HFE to clinical medicine has been alluded to, but its potential has not been fully utilized. The accumulation and analysis of data is slow and tedious, but substantial advances have been made in

the last five years, primarily due to increasing interest in the field. While the HFE is not meant to replace the conventional ECG, it is designed to augment and to improve the diagnostic ability of the electrocardiogram. It is not unlikely that the next 20 years may see the appearance of HFE as standard equipment in medical centers and larger hospitals.

REFERENCES

1. Oppenheimer, B.S., Rothchild, M.A.: Electrocardiographic changes associated with myocardial involvement, *JAMA* 69:429, 1917.
2. Langner, P. H.: Value of high fidelity electrocardiography using the cathode ray oscillograph and an expanded time scale, *Circulation* 5:249, 1952.
3. Langner, P. H.: High fidelity electrocardiography: Further studies including the comparative performance of four different electrocardiographs, *Am. Heart J.* 45:683, 1953.
4. Boyle, D., Carson, P., Hamer, J.: High frequency electrocardiography in ischaemic heart disease, *Brit. Heart J.* 28:539, 1966.
5. Langner, P. H., DeMott, T., V.M.D., Hussey, M., B.E.: High fidelity electrocardiography: Effects of induced localized myocardial injury in the dog, *Am. Heart J.* 71:790, 1966.
6. Anderson, G. J., Muller, B. F., Reynolds, E. W.: Interpretation of the high frequency components in the electrocardiogram as indicating diffuse myocardial disease, *Circulation* 32:II-43, 1965.
7. Reynolds, E. W., Muller, B. F., Anderson, G. J., Muller, B. T.: High-frequency components in the electrocardiogram: A comparative study of normals and patients with myocardial disease, *Circulation* 35:195, 1967.
8. Franke, E. K., Braunstein, J. R., Zellner, D. C.: Study of high frequency components in the electrocardiogram by power spectrum analysis, *Circulation Res.* 10:870, 1962.



Selective Coronary Cinearteriography

WILLIAM C. ELLIOTT, M.D.

SELECTIVE coronary cinearteriography is a means of demonstrating coronary artery disease in living man which rivals the pathologist's examination.¹ This laboratory has been established in order to study the anatomical changes in patients with coronary disease, to correlate these findings with other measurements of severity of the disease and to evaluate the various surgical and medical procedures used in the treatment of coronary artery disease.

Along with arteriograms, the studies will include: (a) correlation of lesions with abnormalities in coronary flow as measured by 85-Krypton (isotope) technic,² (b) abnormalities in myocardial oxygen extraction patterns, (c) myocardial lactic acid metabolism,³ and (d) left ventricular shape, contraction pattern and cardiac output in relation to arterial disease.⁴

The studies of coronary flow, oxygen extraction and lactate metabolism are possible by catheterization of the coronary sinus and sampling venous drainage. By sampling in several positions, it is possible to define areas in which flow is restricted. When coronary flow cannot increase to meet demands, increased oxygen extraction takes place. If the latter does not provide enough oxygen to meet the demands of the myocardium, anaerobic metabolism occurs which can be detected by myocardial lactate production. The heart thus changes from aerobic metabolism in which lactic acid is extracted from arterial blood and used as fuel, to glycolytic metabolism in

which an ischemic myocardium actually produces lactic acid and the venous concentrations of lactate exceeds arterial concentrations. By careful sampling of the coronary sinus in several positions, it is possible to determine if ischemia involves the anterior or posterior aspect of the left ventricle.⁵

Often it is impossible to predict the zone of ischemia from angiograms alone and determination of lactic acid production aids in evaluating the coronary arteriograms. Such a correlation of site of arterial lesion as seen on cinearteriography with proper localization of ischemia using lactate production is important in selecting patients for surgical revascularization.

The objective methods of evaluation outlined above are applied in evaluation of changes of myocardial oxygenation following internal mammary implantation. Blood flow rates can be measured by injecting 85-Krypton solution into the heart

through the implanted internal mammary at the time the patency of the artery is proven angiographically.⁶ There is some evidence that zonal lactate production has been eliminated in some successful internal mammary implantations in which the vessel has provided collaterals to a previously blocked coronary artery.⁷

Studies of cardiac output, mean systolic ejection rate and pattern of contraction add to the functional evaluation of each subject.

Therapeutic Programs

Coronary catheterization, as well as the ancillary metabolic, flow and hemodynamic studies can and do provide a basis for developing an individualized treatment program for each patient (Figure 1).

A. Patients with normal arteriograms and chest pain: Approximately 30% of patients presenting for coronary arteriography with chest pain have no arterial lesions demonstrated. Some clearly have either

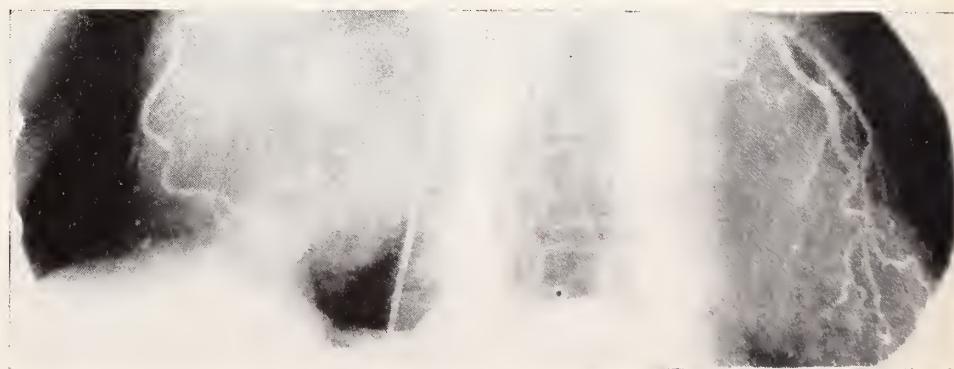


FIGURE 1A AND B

A SELECTIVE injection of the right coronary artery is shown in 1A. A selective injection of the left coronary artery is shown in 1B. Both are normal. The catheter may be introduced into the ostia of the coronary artery either from the brachial or femoral artery. Only three to five ml. of contrast media is used with each injection. Multiple injections are performed in different projections. The vessels are filmed in cine using magnification. Greater detail is obtained by viewing in motion rather than study of single still frame as shown above.

neurosis or non-cardiac type complaints. However, approximately 10% have syndromes of classical angina pectoris or frequent episodes of pain resembling coronary insufficiency. Many are totally disabled by the severity and frequency of their symptoms. The findings of positive exercise electrocardiograms, and myocardial lactate production in a few has spurred efforts to determine the nature of the disorder in this newly emerging syndrome.⁸

Careful exercise testing and coronary circulatory studies will be performed to avoid branding patients as "neurotic" who may have some form of heart disease manifest by pain in spite of normal coronary arteriograms.

B. Patients with abnormal arteriograms and chest pain: Currently, four programs exist for the therapy of conventional angina associated with large vessel coronary artery disease: I.) Nitrites, either long acting or short acting which lower cardiac work and increase collateral blood flow. They may also reverse coronary arteriolar "spasm" if it exists in disease states; II.) Graded exercise leading to physical conditioning which is beneficial by reducing the amount of cardiac work necessary for a given amount of exercise. This may also promote development of collateral circulation; III.) Beta-adrenergic blocking drugs at present, available only for investigation, are effective in reducing angina in over 80% of patients. Their effect on formation of collateral circulation and collateral flow is unknown. These drugs are also effective anti-arrhythmia agents; IV.) Surgical revascularization procedures. Currently one or more internal mammary or intercostal arteries may be implanted and when implanted in areas of ischemia, are thought to lead to development of collateral circulation. Such collaterals are most likely to develop if the arteries are implanted in areas served by a vessel with

at least a 90% stenosis (or total block) and if such area is provided with collaterals and demonstrates zonal lactate production.⁶ Subjective improvement following such surgery has been noted by many and preliminary recatheterization studies have added objective evidence of improvement in some of the subjects.

After baseline arteriographic studies, each patient is given a period of conditioning exercises provided such can be tolerated. In addition, if necessary, patients will be placed on beta-blocking drugs and exercise tolerance determined in our exercise laboratory at each stage of physical conditioning. Nitrites will be used with or without each of the therapeutic programs. Along with these measures, attempts will be made at weight reduction, control of hypertension, use of anti-depressants and sedatives. The effectiveness of one or a combination of the procedures will be measured objectively in the different laboratories.

If medical programs are not effective and the pain remains disabling, the patients will be selected for revascularization procedures.

At the time of surgery, measurements of coronary flow will be made by injection of 85-Krypton solution

directly into the myocardium to determine the area of lowest isotope wash-out. Implantation will then be made into the area of greatest demand for collateral, namely the area with the lowest flow. Such quantitative technics are important when implantation of several vessels is possible.

In some instances direct coronary artery surgery will be done and the results compared with the indirect revascularization technics.

In summary, the coronary cineangiography laboratory supplemented by the metabolic laboratory and in collaboration with the other laboratories involved in coronary artery disease study is involved in a long-term study of patients with coronary atherosclerosis (Figure 2).

REFERENCES

1. Kemp, H. G., Evans, H., Elliott, W. C., Gorlin, R.: Diagnostic accuracy of selective coronary cine arteriography, *Circ.* (in press).
2. Cohen, L. S., Elliott, W. C., Gorlin, R.: Measurement of myocardial blood flow using Krypton-85, *Am. J. Physiol.* 206:997, 1964.
3. Cohen, L. S., Elliott, W. C., Klein, M.D., Gorlin, R.: Coronary heart disease: Clinical, cinearteriographic and metabolic correlations, *Am. J. Cardiol.* 17:153, 1966.

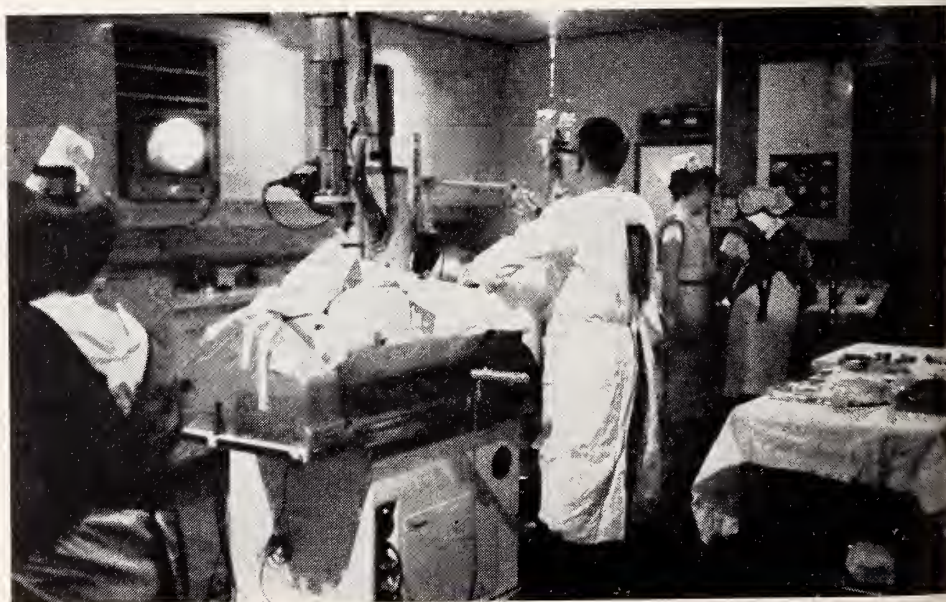


FIGURE 2

THE coronary cineangiographic laboratory equipped with close circuit television and instant video-tape replay.

4. Klein, M.D., Herman, M. V., Gorlin, R.: A hemodynamic study of left ventricular aneurysm, *Circ.* 25:614, 1967.
5. Herman, M. V., Elliott, W. C., Gorlin, R.: An electrographic anatomic and metabolic study of zonal myocardial ischemia in coronary heart disease, *Circ.* (in press).
6. Taylor, W. J., Gorlin, R.: Objective criteria for internal mammary implantation, *Annals of Thoracic Surg.* (in press).
7. Gorlin, R., Taylor, W. J.: Selective revascularization of the myocardium by internal mammary implant, *New Eng. J. Med.* 275:283, 1966.
8. Kemp, H. G., Elliott, W. C., Gorlin, R.: The angina syndrome with normal coronary arteriography, *Trans. Am. Assoc. Phys.*, 1967. ◀

New DISPETTE™ Single dose disposable units

- No measuring—no droppers—no bottles
- Full dosage without waste or spillage
- Space-saving refrigerator package
- Practical and economical

**Poliovirus Vaccine
Live, Oral, Trivalent**

ORIMUNE®



CONTRAINDICATIONS and PRECAUTIONS: Do not inject this vaccine. Postpone vaccination in those with acute illness; in any condition having an adverse effect on the immune response mechanism (leukemias, lymphogenous diseases, dysgammaglobulinemias, during treatment with immune serum globulins or with cancer chemotherapy agents, etc.); in advanced debilitated states; or if there is persistent vomiting or diarrhea, or clinical signs of virus (including enterovirus) infection.

Live measles and oral poliovirus vaccines should probably be given separately.

SIDE EFFECTS of significance have not been reported. However, the risk of vaccine-induced poliomyelitis, estimated to be from 1:2,500,000 to 1:50,000,000 should be considered.

Supplied in trays of 10. Order through your Lederle Representative or regular source of supply.



447-7-4964



Cardiovascular Uses of Diagnostic Ultrasound

HARVEY FEIGENBAUM, M.D.

FOR nearly four years we have been working with ultrasound in an attempt to utilize this form of physical energy for diagnostic purposes in cardiology. By definition, ultrasound is sound with a frequency greater than 20,000 cycles per second. Sound with frequencies this high cannot be detected by the human ear. Although the physical properties of ultrasound are essentially the same as low frequency sound, the small wave length associated with ultrasound provides some distinct advantages. First of all, with a smaller wave length there is less tendency for the sound to scatter, and the apparatus necessary to focus the sound is much smaller. Thus, it is considerably easier to direct ultrasound in a straight beam. Secondly, the ability of an object to reflect or refract sound waves depends on the relative size of the object with respect to the wave length of the sound beam. Any object smaller than one fourth the size of the sound wave length will have no effect on the sound beam. In order to obtain a reflected sound wave or echo from a small object, one must use a sound beam with a wave length less than four times the size of the object. Ultrasound with its shorter wave length can obtain echoes from much smaller objects and thus has far greater resolution than low frequency sound. In clinical medicine, the actual frequencies used are between one to seven megacycles or 1,000,000 to 7,000,000 cycles per second.

Most investigators using ultrasound for diagnostic purposes use the technic of recording reflected

ultrasound. This technic, which is similar to naval sonar, utilizes the principle that when ultrasound crosses a boundary or interface between two media with different acoustical impedance, some of the waves are reflected while the remainder continue through the second medium. Acoustical impedance is the product of density times the velocity sound travels through that medium. Thus, ultrasound waves will be reflected by an interface between gas and liquid, liquid and solid, or solids of different densities. The amount of sound which is reflected depends upon the magnitude of the acoustical difference between the two media and, like light, the angle of incidence of the beam with the interface.

This technic requires a transducer which is capable of both emitting and receiving ultrasound. This requirement is met by having the transducer transmit one microsecond ultrasonic impulses intermittantly at rates of either 200, 1,000, or 2,000 times per second. Between impulses, the transducer acts as a receiver and records the reflected sound waves. These reflected sonic impulses (echoes) activate the crystal and are converted into electrical signals which can be displayed on an oscilloscope screen.

Water As Medium

Figure 1A depicts what would be detected with an ultrasonoscope if the ultrasound beam were directed through a beaker of water. On the "A scan" presentation there would be a signal or echo originating from the transducer (T). Since the water is a homogeneous medium, no sound

will be reflected until the beam hits the opposite side of the beaker. The sound is then reflected and returns to the transducer. Knowing the velocity of sound through water and knowing how long it took for the one microsecond burst of ultrasound to go from the transducer, hit the opposite side of the beaker and then return to the transducer, the distance from the reflected interface to the transducer can be calculated. This calculation is made electronically and on the "A scan", amplitude of the echo is plotted against distance in centimeters.

If one introduces an object with a density or acoustical impedance different than water in the path of the ultrasound beam, this object will reflect part of the ultrasound waves and will produce an echo on the ultrasonoscope (Figure 1B). Part of the ultrasound waves will continue through the object and the echo from the far wall of the beaker will again be recorded.

If the object introduced into the water moves (Figure 1C), then the echo from that object will also move. Such movement will be noted on the ultrasonoscope as lateral motion of the signal. For a permanent recording of such motion, the "B mode" or "time-motion scan" is preferable to the "A scan." With this type of echo display, the signals are converted to bright dots, time is substituted for amplitude, and the resultant oscilloscopic image has distance plotted against time (Figure 1C). With the B scan a time exposure photograph is all that is necessary to record motion. Another way of

recording motion is by singling out a particular echo using a gating device and then inscribing the movement of the echo on a strip-chart recorder via an analogue output attachment. Figure 2 illustrates how the motion of the echo originating from the posterior wall of the heart can be displayed on a strip-chart recorder together with an electrocardiogram and phonocardiogram. Since the ultrasonic impulses are being sent and received at a rate of 200 to 2,000 per second, the resultant recording is essentially continuous.

Advantages of Ultrasound

When applied to medicine, ultrasound is similar to diagnostic x-ray in that it essentially provides another method of examining structures which lie beneath the surface of the skin. Probably the primary advantage of ultrasound is that its capability for distinguishing interfaces between objects of different density is far more sensitive than x-ray. There are a large number of substances which are not radio-opaque, but which can be detected easily with ultrasound. For example, it is very simple for ultrasound to distinguish between liquid and human soft tissue. This differentiation is virtually impossible with x-ray. A practical application of this capability is the use of ultrasound in detecting pericardial effusion. A chest roentgenogram or fluoroscopy only provides an outline of the cardiac silhouette. With ultrasound, one can record structures within that silhouette.

Another advantage of ultrasound is that in the power levels used for diagnostic purposes, it has been shown thus far to be completely harmless. The power output is approximately 0.012 watts/cm², which is considerably less than the 1.3 watts/cm² used in ultrasound therapy. Ultrasound examinations have been done on literally thousands of patients all over the world for over ten years,¹ and not a single untoward

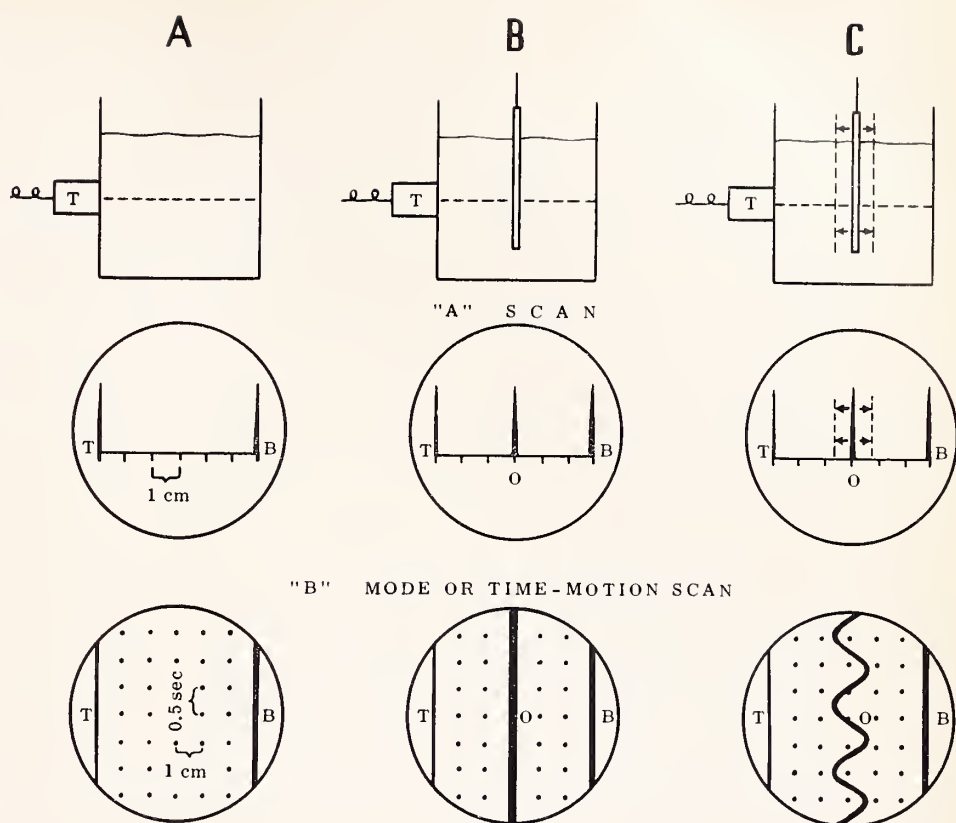
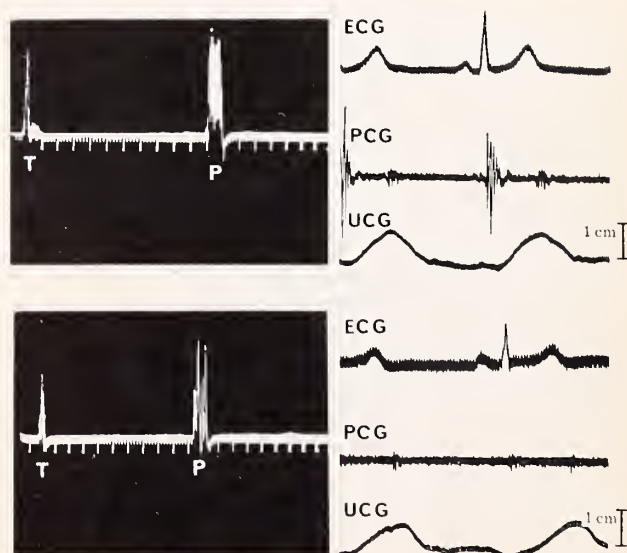


FIGURE 1
DIAGRAMS illustrating the theory behind the use of reflected ultrasound for diagnostic purposes. (See text).

reaction has been reported. There have been numerous toxicity studies done on experimental animals with still no apparent ill effects from diagnostic ultrasound.² As a result, in some situations ultrasound is being used as a substitute for x-ray merely to avoid the hazard of radiation. An example of this is the use of ultrasound in obstetrics.

Yet another feature of ultrasound is that many of the medical applications can be done with commercially available equipment which is portable, permitting the examination to be done at the bedside. Figure 3 shows the ultrasonoscope used in our laboratory. Thus, the technic is ideal for patients who may be critically ill and should not be moved.

FIGURE 2
ULTRASOUND recordings of the posterior heart wall (PW) in two normal subjects. The photographs on the left represent "A scan" presentations, and the recordings on the right are made with a strip-chart recorder utilizing an analogue output attachment. (From Feigenbaum, H., Waldhausen, J.A., Hyde, L.P.: Ultrasound diagnosis of pericardial effusion, JAMA 191:711, 1965. Reprinted by permission of American Medical Association).



Cardiovascular Uses of Diagnostic Ultrasound (Ultrasonocardiography or Echocardiography)

Among the clinically useful applications of ultrasonocardiography are the detection of mitral stenosis,³⁻⁵ pericardial effusion,⁶⁻¹¹ and abdominal aneurysms.¹² The theory and method for detecting mitral stenosis and pericardial effusion were described in an earlier article in this journal.¹³ Instead of repeating what was covered in that article, this discussion will describe one of the newer applications of diagnostic ultrasound and one which may broadly enhance the clinical and investigative usefulness of ultrasound cardiography. This application is the development of a technic for measuring left ventricular stroke volume.

The technic stems from the finding of an echo which appears to originate from an area of the left ventricle near the mitral ring or annulus.¹⁴ The echo was thus designated as the mitral ring echo or MRE. It became apparent that the curve which this echo inscribed was quite similar to a ventricular volume curve. Twenty-five normal subjects were examined and it was noted that the amplitude of the mitral ring echo (MREa) was roughly proportional to the expected stroke volume according to body surface area.¹⁴ Thus, it was theorized that the amount of motion exhibited by this echo could be used

to calculate left ventricular stroke volume (LVSV) in intact human subjects.

However, in dealing with patients with abnormal hearts and differing heart size, MREa alone was insufficient for calculating LVSV. It is well known that a given absolute change in diameter of a large chamber will produce a larger stroke volume than will the same change in diameter of a smaller chamber. Figure 4 illustrates this point. A sphere with an initial diameter of 10 cm has a volume of 523 cm³ (Figure 4A). If the diameter were decreased by 2 cm to 8 cm, the volume would now be 268 cm³. The resultant difference or change in volume would be 255 cm³. If the sphere's diameter originally was 6 cm, the same 2 cm decrease in diameter would only produce an 80 cm³ change in volume.

In order to solve this problem, an attempt was made to obtain an estimate of left ventricular volume. It

is possible to record echoes from both the anterior and posterior walls of the heart. An empirical observation was that the distance between the two echoes seemed to correlate with the size of the left ventricle. Thus, this ultrasound measurement could possibly provide the necessary estimation of left ventricular volume for the calculation of left ventricular stroke volume from the amplitude of the mitral ring echo. The basic hypothesis was that left ventricular wall motion (LVM) was proportional to left ventricular stroke volume (LVSV) and inversely proportional to left ventricular volume (LVV) or $LVM \sim \frac{LVSV}{LVV}$. Substituting MREa for LVM and the ultrasound measurement of left ventricular diameter (LVD) for LVV, the formula is $MREa \sim \frac{LVSV}{LVD}$ or $LVSV \sim MREa \times LVD$.

This hypothesis was tested on 16 patients who had no mitral or aortic insufficiency and who were undergo-

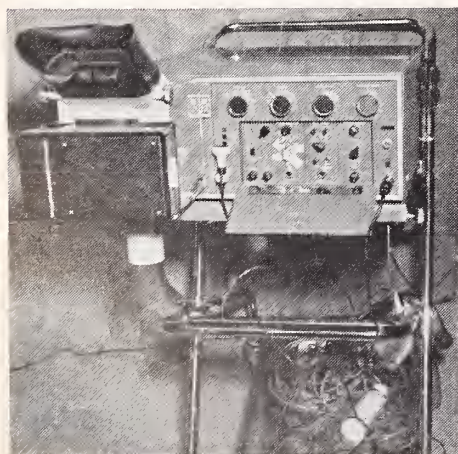


FIGURE 3

COMMERCIAL ultrasonoscope used in this laboratory.

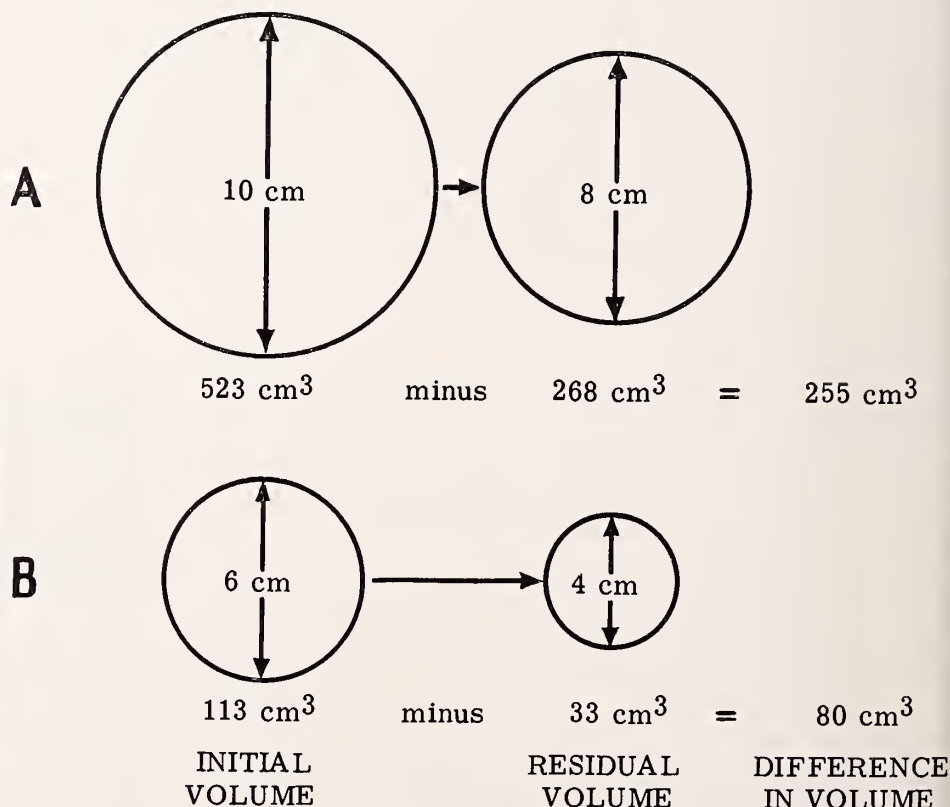


FIGURE 4

DIAGRAMS demonstrating how a given change in diameter of a large sphere produces a larger change in volume than an equal diameter change in a smaller sphere.

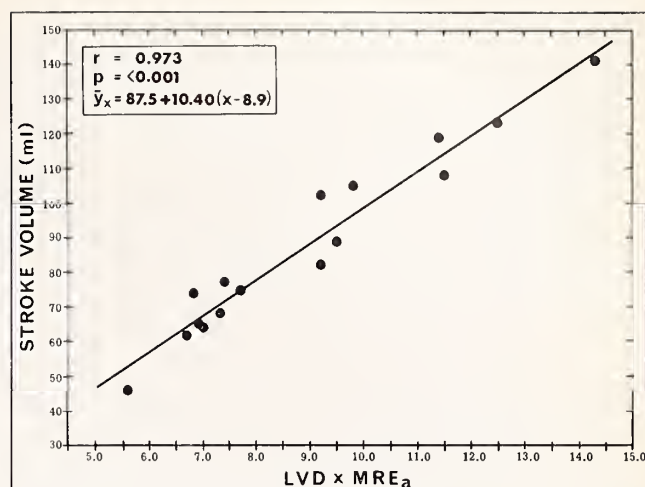
ing cardiac catheterization.¹⁵ Ultrasound measurements of MREa and LVD were obtained simultaneously with the determination of cardiac output utilizing the Fick technic. The correlation between the stroke volume as measured by the Fick method and MREa x LVD was excellent ($r = 0.973$, $p < 0.001$) (Figure 5). When the statistical regression equation $y = 37.5 + 10.40 (x - 8.9)$ was used to predict stroke volume from the ultrasound measurements, the difference between the calculated ultrasound stroke volume (SV_U) and the Fick stroke volume (SV_F) was ± 11 ml or $\pm 15\%$.

This work was followed up by obtaining simultaneous SV_U and SV_F measurements on 31 patients with mitral or aortic insufficiency.¹⁶ In all cases, SV_U exceeded SV_F and the difference correlated well with the amount of valvular insufficiency as determined with selective cineangiography (Table I). The mean difference of SV_U and SV_F was 15 ± 6 ml for 15 patients with mild insufficiency, 33 ± 5 ml for six patients with moderate insufficiency, and 63 ± 21 ml for ten patients with marked insufficiency. The means of the three groups were significantly different ($p < 0.001$). This work further supports the validity of the ultrasound technic for measuring left ventricular stroke volume and provides a method of quantitating mitral or aortic insufficiency.

Future Uses

There are many other potential cardiovascular uses of ultrasound

FIGURE 5
GRAPH plotting stroke volume as determined by the Fick method against the product of the ultrasound measurements LVD x MREa. (From Feigenbaum, H., Zaky, A., Nasser, W.K.: Use of ultrasound to measure left ventricular stroke volume, *Circulation*, in press).



which are currently being investigated. Measurement of left ventricular diastolic volume and left ventricular wall thickness are only two of the areas being studied. The fact that diagnostic ultrasound is absolutely safe and the examination can be done in a matter of minutes as a bedside

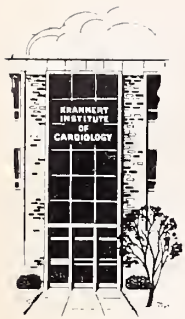
procedure will continue to prompt investigators to search for further uses of this intriguing diagnostic tool.

(A copy of the references pertaining to this paper may be obtained by writing The Journal office.)

SIMULTANEOUS ULTRASOUND STROKE VOLUME, (SV_U) AND FICK STROKE VOLUME (SV_F) IN PATIENTS WITH MITRAL OR AORTIC INSUFFICIENCY

Mild mitral or aortic insufficiency — 15 patients			
	SV_U	SV_F	$SV_U - SV_F$
mean	70	55	15
SD	± 17	± 15	± 6
range	47-101	37-90	10-27
Moderate mitral or aortic insufficiency — 6 patients			
	SV_U	SV_F	$SV_U - SV_F$
mean	85	52	31
SD	± 20	± 22	± 6
range	74-126	38-95	27-40
Marked mitral or aortic insufficiency — 10 patients			
	SV_U	SV_F	$SV_U - SV_F$
mean	120	57	63
SD	± 29	± 21	± 21
range	79-164	38-100	37-100

TABLE I



Coronary Blood Flow

SUZANNE B. KNOEBEL, M.D.
PAUL L. McHENRY, M.D.

IN the search for significant environmental, biological or dietary factors in the etiology of coronary artery disease, it becomes important to identify those individuals in each population who have atherosclerosis. Atherosclerosis has been aptly called an "iceberg" disease as only five to ten percent of affected persons show clinical signs or symptoms. Coronary arteriography is not sufficiently simple, accurate or safe to be used as a screening procedure for the general population. The exercise electrocardiogram has applicability but has not been shown to have sensitivity of the required degree.

In addition, no technic has been developed to allow the practical assessment, in the living patient, of collateral arterial development following myocardial infarction as a part of the natural history of the disease or as the result of any particular therapeutic program such as drugs, exercise and diet.

Consequently, a technic for the measurement of coronary blood flow (CBF) in the human has been developed in this laboratory for the specific purposes of (1) evaluating this measurement as a means of detecting coronary artery disease in asymptomatic patients and as a diagnostic procedure in patients having atypical chest pain and (2) determining if serial measurements of coronary blood flow will reflect the development of collateral blood flow post-myocardial infarction.

Materials and Methods

The technic is dependent on precordial counting of the myocardial uptake of $^{84}\text{RbCl}$ following a single

slug intravenous injection of the isotope. The myocardial uptake of ^{84}Rb is measured using a coincidence counting system (Co-Insitron)* as developed by Bing and associates.¹ The instrument consists of two pairs of coincidence detectors, one four-inch in diameter and one two-inch in diameter, and a conventional well counter for continuously monitoring arterial specific activity. The four-inch scanning pair is directed over the center of the cardiac silhouette by an aiming device, the location having been previously determined by fluoroscopy. The second counting pair (two-inch) is positioned over the right hemithorax cephalad to the liver dome to count the uptake of the isotope by the chest walls exclusive of the heart. Uptake of the myocardium is then expressed as the difference between the left and right side counting pairs, after correction for the efficiencies of the two crystal pairs. 0.2 microcuries of $^{84}\text{RbCl}$ /kg are injected into an antecubital vein through an 18 gauge needle attached to a three-way stopcock and followed by a 10 ml saline flush. Simultaneously arterial blood is withdrawn from a 17 gauge Cournand needle in a brachial artery. The arterial blood is passed through a radiocoin inserted into a well counter. A picture of the equipment is seen in Figure 1.

Calculations

CBF is calculated by the formula:

$$\text{CBF} = K \times q(t) / \int_0^{\infty} A_o(t) dt$$

where K represents the factor determined for each patient to convert

* American Science and Engineering.

the coincidence counting values to values comparable to arterial counts from the well counter and to correct for transmission factors present when the patient is in place. The quantity q is the average myocardial uptake as counted for three minutes. $A_o(t)dt$ represents the arterial blood concentration of the isotope during the first circulation as determined by extrapolation of the downslope.

Discussion

If CBF is to be measured quantitatively in man by isotope technics utilizing precordial counting, a first requisite is that the myocardium be isolated from other sources of radioactive emission seen by the counters.^{2,3} The Co-Insitron has significantly enhanced this ability. The technic is a modification of Sapirstein's observations in rats and dogs that the fractional uptake of ^{86}Rb or ^{42}K by the heart equaled the fraction of the cardiac output (CO) received by the heart.^{4,5} Therefore, CBF could be determined by the following proportion: $\text{CBF}/\text{CO} = \text{Myocardial uptake}/\text{Total body uptake}$

When the total body uptake and organ uptake cannot be determined by such direct means as utilized by Sapirstein, the quantity of isotope injected Q can be substituted for total body uptake and q for organ uptake as monitored externally, provided myocardial isolation is possible; and the calculation for CBF becomes:

$$\text{CBF}/\text{CO} = \frac{q(t)}{Q}$$

The CO can be determined in the usual way by integrating the first arterial circulation curve of the isotope after exponential extrapolation of the downslope.

$\text{CO} = Q / \int_0^{\infty} A_o(t) dt$ where $A_o(t)$ represents the arterial blood concentration of the isotope during the first circulation, determined by extrapolation after recirculation begins.

In the course of a few circulations, the indicator has nearly completely

entered the tissues and $q(t)$ has reached a relatively stable value which changes only slowly because of the large volume of distribution for the indicator in the myocardium. The formula for the calculation of CBF then becomes:

$$CBF = q(t) / \int_0^{\infty} A_o(t) dt$$

Previous determinations of coronary blood flow in the human have been necessarily expressed in terms of milliliters per minute per 100 g of myocardium (or left ventricle).^{6,7} The results of this method are expressed in ml/min/total heart. Comparison of flows determined by the nitrous oxide inhalation technic, which has furnished almost all of the information available regarding coronary blood flow in humans, with our data can, thus, only be approximated. Using the nitrous oxide technic, Bing⁸ found the average CBF in a series of normal subjects to be 77 ml/min/100 g of left ventricle. Rowe,⁹ in 1959, reported a total of 84 subjects of both sexes and an average age of 31 years. The mean CBF in this group was 80.6 ml/min/100 g. Similar values have been reported per 100 g of myocardium as derived by other technics. If the average weight of the heart may be taken as 300 g and if it is assumed that flow per unit weight is uniform, the extrapolated average CBF would be approximately 200-230 ml/min for the nitrous oxide technic. It is presumed that it is from such extrapolation that values for total myocardial blood flow have been derived and reported.¹⁰ The average resting CBF for 33 normal subjects as determined in this laboratory was 269 ml/min/total heart which represented 5.2% of the simultaneous cardiac output.¹¹

If this technic can be accepted to give an approximate measure of nutrient CBF per total heart, the pertinent question is the value of such a measurement. The work of Cohen and associates¹² would suggest that CBF determinations will not distin-

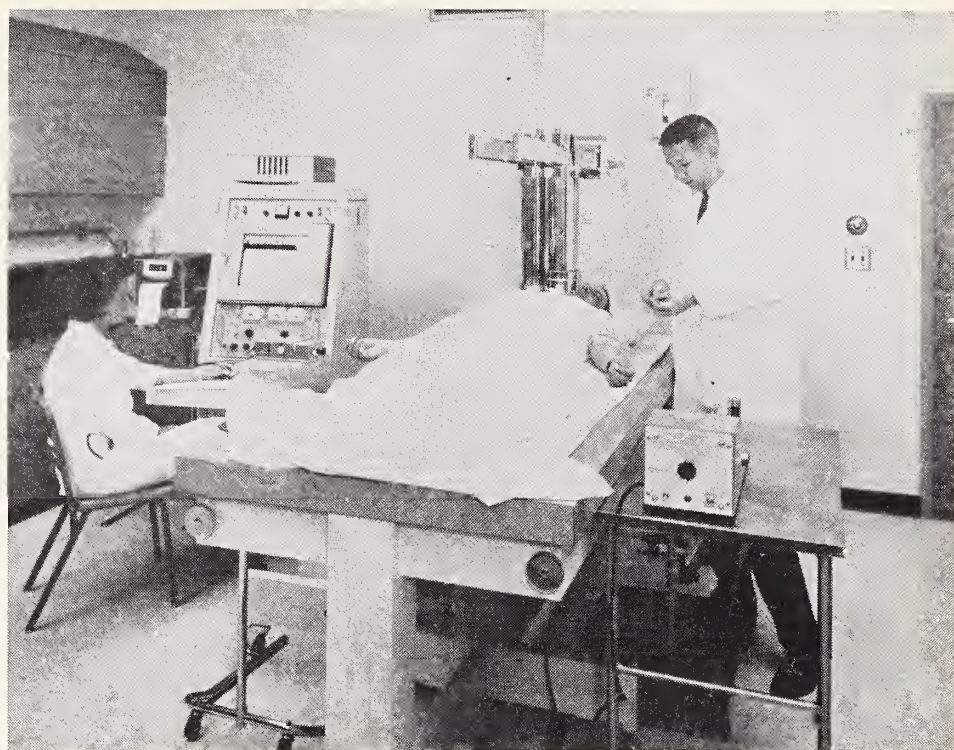


FIGURE 1
THE Co-Insitron in use at the Krannert Institute of Cardiology.

guish patients with coronary artery disease from normal subjects either at rest or during an applied stress such as exercise or isoproterenol infusion. These flow studies were done by a 85-Krypton clearance technic. It is possible that ischemic areas do not take up the Krypton indicator and thus do not contribute to a delayed clearance curve. As a result only the flow through normal vessels is measured. The coincidence technic depends on an average myocardial uptake of indicator. Unperfused areas then contribute to the CBF value by adding a zero value to the obtained average.³ Preliminary studies in this laboratory in patients with proven coronary heart disease do indicate that when total CBF is measured in response to exercise, an appropriate increase in CBF is not demonstrated. It is necessary, however, to evaluate further in these patients the variable relationship between CO and CBF; for there are different energy requirements for ejection of equal increments of output against high or low blood pressures.¹³

Another possibility to be considered

when assessing CBF in patients with coronary heart disease is that those who survive myocardial infarction or who have angina without infarction may be those who have developed coronary artery collaterals¹⁴ and thus may respond normally to an applied stress.

Because of the unique feature of the coincidence counting method that the flow measured represents flow through true capillaries, it is possible that serial measurements in response to stress could reveal such development of nutrient collaterals in the course of recovery from myocardial infarction, treated and untreated.

Coronary Blood Flow In Animals

Utilizing the coincidence counting technic as described in this issue for humans, the measurement of nutrient coronary blood flow (CBF) in animals under varying experimental conditions is an important continuing investigational effort at the Krannert Institute of Cardiology. While caution needs to be exercised in transferring information derived from animal experimentation directly to humans, certain physiological principles can be investigated more completely

under these conditions; and, these principles may be kept in mind when dealing with human disease.

Cardiogenic Shock: A major area of investigation has been the relationship of CBF to the therapy of cardiogenic shock. In the presence of severe coronary disease, the blood flow to the myocardium becomes pressure dependent. When the mean aortic pressure falls to shock levels, the myocardial oxygen supply may be severely compromised. Hence, increased aortic pressure is essential for myocardial perfusion.¹⁵ At the same time, however, it has become increasingly clear that in cardiogenic shock, the cardiac output (CO) is reduced out of proportion to the reduction in mean arterial pressure; thus, a high total peripheral resistance is calculated. Consequently, the rationale for employing drugs with strong vasoconstrictive properties has been questioned.¹⁶ Perhaps priority should be placed on effecting an optimum increase in myocardial contractility while ensuring an adequate venous return. In this way, arterial pressure is raised by increasing the cardiac output.

In order to study this problem, cardiogenic shock is produced in anesthetized dogs by coronary embolization. A calculated dosage of plastic microspheres from 297 to 350 microns in diameter are injected through the inner lumen of a carotid cannula and flushed with 10 cc of saline. Coronary shock is considered

to be present when there is (1) an initial reduction of CO of 50% or greater, (2) a 35% or greater reduction in mean arterial blood pressure and (3) ECG evidence of ischemic myocardial damage. The dogs are then managed according to a protocol by random allocation. One-fourth are used as control animals, one-fourth are treated with an infusion of norepinephrine, one-fourth are treated with isoproterenol and one-fourth receive Dopamine.

While the data is not complete at this time, early results seem to indicate that, as expected, the CBF is directly related to the CO and both norepinephrine and isoproterenol effect an increased CO. The critical question is whether the two drugs differ in their effects upon the work of the heart.

Alcohol and CBF: Also of considerable clinical significance is the effect of alcohol on CBF. In medical practice, alcohol consumption in moderation is usually considered innocuous or, indeed, beneficial in patients with atherosclerotic heart disease.¹⁷⁻²⁰ On the other hand, it has been reported that alcoholic beverages do not shorten the duration of anginal attacks, nor improve favorably the exercise ECG.^{21,22}

Our studies were designed to investigate the effect of ethyl alcohol on nutrient CBF in anesthetized dogs using the coincidence counting technique. Twelve dogs have been studied.

In all 12, CBF showed a decrease after IV alcohol injection. The blood alcohol levels ranged between 155 and 220 mg %. The average drop in CBF was 18% of the control CBF value. There were no significant changes in heart rate or blood pressure.

In general our results indicate that the widespread belief that the coronary arteries are dilated and coronary flow increased by moderate doses of alcohol is probably not correct. Nonetheless, angina may be relieved by alcohol ingestion.^{17,18,22,23} Whether or not the euphoria produced by alcohol is salutary or whether other metabolic effects yet to be defined are in operation is unknown. As Dr. Morris Fishbein has stated "Like the warnings on tobacco packages, the caution is not likely to lead to a tremendous increase in the number of total abstainers."

Summary

A technic for the measurement of coronary blood flow (CBF) in man and animal has been described. The characteristics of the method are discussed in relationship to possible clinical application for the measurement of CBF. The technic is simple and may be utilized as a general screening procedure.

(A copy of the references pertaining to this paper may be obtained by writing The Journal office.) ◀



Let's be specific about Campbell's Soups... and *reducing diets*

There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

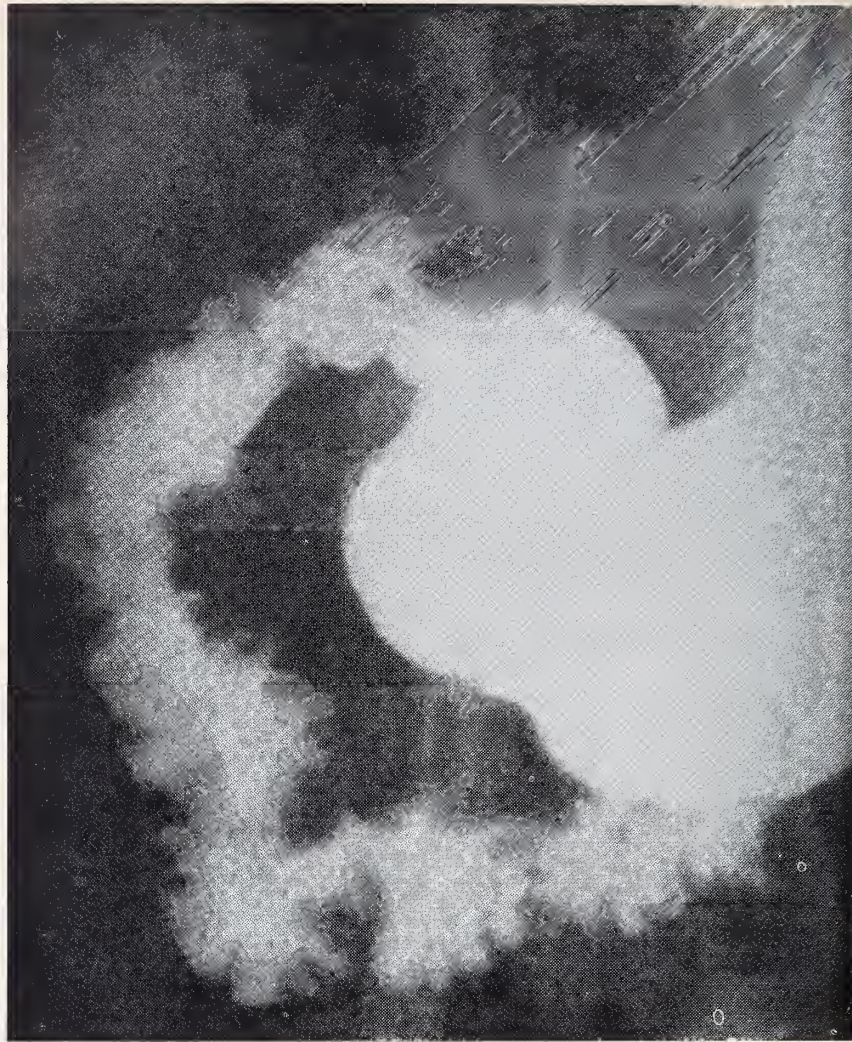
Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



Conventional Radiography

The restless duodenum makes radiographic diagnosis difficult, uncertain and often unproductive: Is this duodenum abnormal?



Hypotonic Duodenography

Pro-Banthine-induced duodenal calm permits full anatomic appraisal: Same patient. Duodenal normality is now evident.



- in diagnosis
- in treatment

Pro-Banthine[®]

brand of
propantheline bromide

calms the gastrointestinal tract

For fifteen years Pro-Banthine has been the most widely used anticholinergic agent in disorders of gastrointestinal motility and gastric hypersecretion. More recently Pro-Banthine has reestablished its pharmacologic effectiveness in diagnostic procedures using intragastric fibroscopy and hypotonic roentgenography.

How the X-rays were taken

In the hypotonic duodenograph^{1,2} reproduced above, the gastrointestinal tract was relaxed with Pro-Banthine. The duodenum was intubated. Pro-Banthine in a dose of 60 mg. intramuscularly was used to assure prompt aperistalsis and double-contrast visualization was achieved with ordinary barium and air.

The same pharmacologic efficiency has proved of pronounced value in such conditions as: *peptic ulcer, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.*

Contraindications: Glaucoma or severe cardiac disease.

Precautions: Since varying degrees of urinary hesi-

tancy may occur in elderly males with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

(1) Bilbao, M. K.; Frische, L. H.; Rösch, J., and Dotter, C. T.: Hypotonic Duodenography, Scientific Exhibit, Radiological Society of North America, Chicago, Nov. 27-Dec. 2, 1966.


(2) Bilbao, M. K.; Frische, L. H.; Dotter, C. T., and Rösch, J.: Hypotonic Duodenography, Radiology, in press.

SEARLE

Preludin[®] phenmetrazine hydrochloride



For complete details,
please see full
Prescribing Information.



helps keep calories at arm's length

Preludin is indicated only as an anorectic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension, or pregnancy. For use in pregnancy, see Warning.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets® prolonged-action tablet a day, taken by midmorning.

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.



Warning: Do not use during first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations, or delusions. Do not exceed recommended dosage.

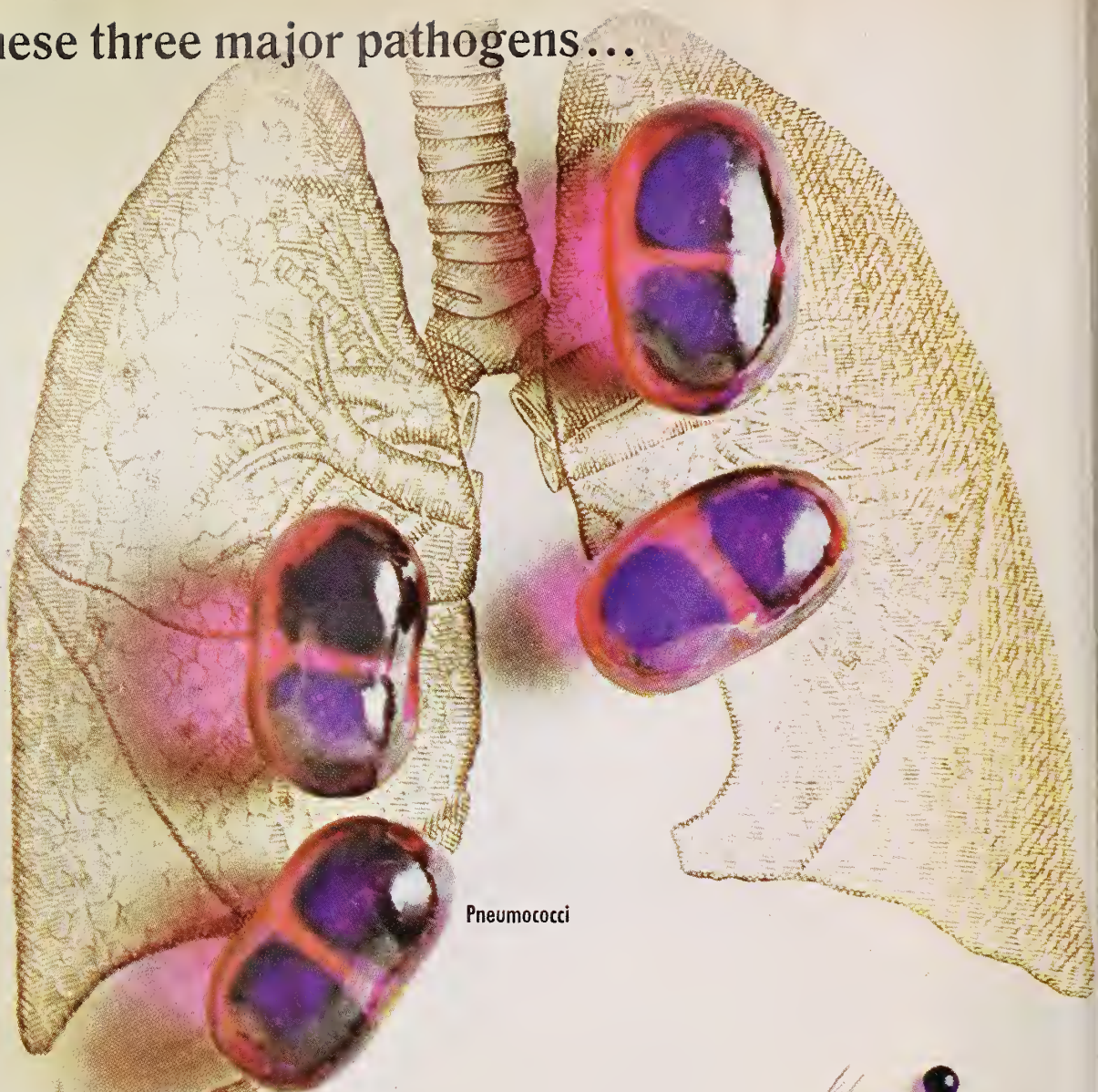
Side Effects: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache. (B)R46-560-A



Geigy Pharmaceuticals, Division of
Geigy Chemical Corporation, Ardsley, N.Y.

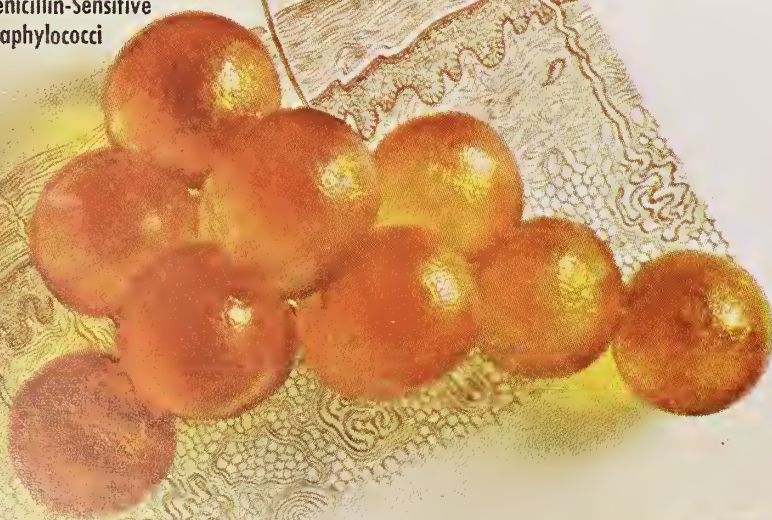
Under license from
Boehringer Ingelheim G.m.b.H.

Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



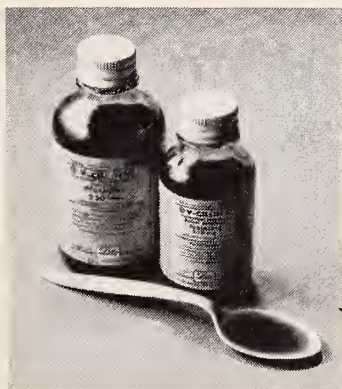
V-Cillin K[®] provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.

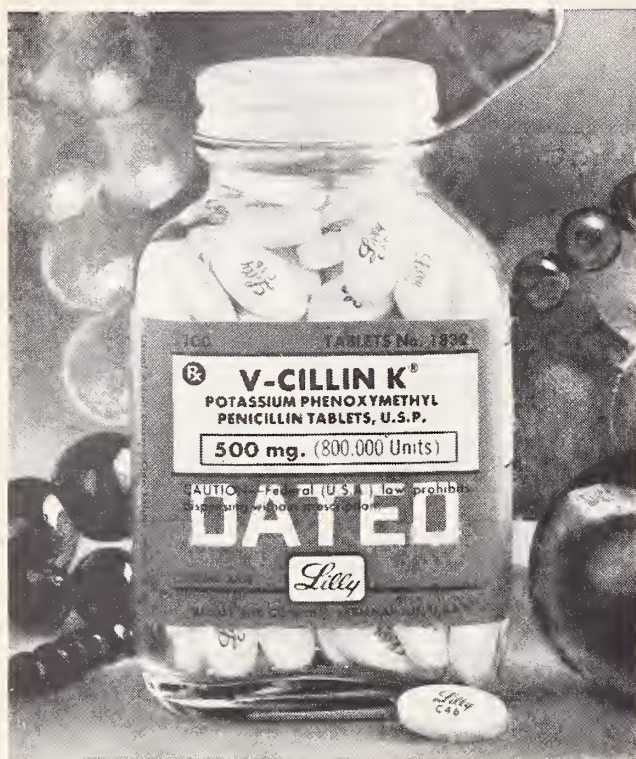


V-Cillin K[®] 701449 Potassium Phenoxyethyl Penicillin

Now available: V-Cillin K[®], Pediatric,
for Oral Solution, 250 mg. (400,000 units)
per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.





Electrophysiology Laboratories

KALMAN GREENSPAN, Ph.D.

ROBERT E. EDMANDS, M.D.

THE electrophysiology laboratories of the Krannert Institute of Cardiology constitute an integral part of the overall cardiovascular research program. This is true for several reasons. Cardiac electrophysiology is the study of the electrical properties of the heart, both under normal conditions and under conditions of altered environment (drug administration, electrolyte alteration, etc.) and information derived from such studies is of great potential value in the clinical practice of medicine. For example, electrophysiologic techniques have elucidated the mechanism by which digitalis exerts a therapeutic effect on atrioventricular conduction as well as the mechanism whereby toxic arrhythmias are evoked. This technique has permitted an evaluation and some insight into the factors associated with the production and perpetuation of the lethal arrhythmia in acute myocardial infarction. As a consequence of such studies, identifying the basic causative factor in conduction disturbance and arrhythmia formation, the appropriateness of current therapy, as well as the utility of potential therapeutic agents may be evaluated.

In-vivo Technic

There are two basic methods of investigation appropriate to the electrophysiologic discipline. The first is that of the in-vivo technic, involving the study of intact, experimental animals. Typically, the anesthetized animal undergoes thorocotomy and exposure of the heart. Then, multiple electrodes may be implanted upon either atria and ventricle, in the SA

nodal and AV junctional area, either for the purpose of recording electrogram or for the direct administration of electrical stimuli. In this manner, the effects of drug administration and/or electrolyte variation upon normal and ectopic impulse formation, AV conduction and intraatrial and intraventricular conduction may be assessed. The routine electrocardiogram is taken simultaneously in order that the observed phenomena may be more directly correlated with customary clinical data. The relation of the autonomic nervous system to these events may also be assessed by enhancing or excluding vagal or sympathetic influences. Isolation and electrical stimulation of the cervical vagus nerve, atropinization or catecholamine depletion (produced by cardiac denervation, B-adrenergic blockers, guanethidin or reserpine) permits a more precise definition of the mechanism of drug or electrolyte action and, hence, a more objective rationale for clinical therapy.

Information of substantial clinical value has been derived from such electrophysiologic studies already, while much more work remains to be accomplished in this young, dynamic discipline. Of particular pertinence have been the studies of Fisch et al.¹⁻¹¹ delineating the relation between potassium administration and the various manifestations of digitalis toxicity. Potassium administration had long been considered a panacea for all cardiac manifestations of digitalis. The aforementioned studies have rather conclusively demonstrated, however, that such is not the case. The exogenous administration

of K⁺ is indeed of benefit in those cases where the toxic manifestation of digitalis is that of enhanced impulse formation (i.e., paroxysmal atrial tachycardia with block, frequent ventricular ectopic impulses, nodal or ventricular tachycardia, etc.) and the serum K⁺ concentration is low or normal. On the other hand, in those cases where digitalis toxicity is manifested primarily by an AV conduction disturbance, K⁺ elevation actually augments the conduction disturbance produced by digitalis.^{12,13} Electrophysiologic data exists, moreover, which suggests that K⁺ administration should be undertaken only with great circumspection in the presence of digitalis toxicity of any type; for rapid infusion of K⁺ may quickly produce lethal levels of serum K⁺ in the presence of digitalis toxicity.

Further electrophysiologic contributions of the Krannert Institute of Cardiology include studies of the effects of hyperkalemia upon cardiac rhythm and upon the cardiac responsiveness to an implanted pacemaker,^{14,15} the inefficiency of counter-shock in digitalis-induced arrhythmias,¹⁶ and the cardiac responsiveness to vagal stimuli at various stages of digitalis administration.

In-vitro Technic

The second basic method of electrophysiologic investigation involves in-vitro rather than in-vivo studies. That is, electrophysiologic studies may be performed on isolated segments of cardiac tissue, excised from the experimental animal (and, occasionally, from the human in the case

of mitral-valve replacement, during which papillary muscles are routinely excised). The basis of this technique is the glass microelectrode first introduced by Ling and Gerard¹⁷ and adapted for cardiac cells by Draper and Weidmann¹⁸ and others.^{19,20} This electrode is essentially a soft glass tube which is drawn out to an extremely fine tip (less than 0.5 micron in diameter). The tip dimension is sufficiently small to eliminate the possibility of cell damage upon impalement. The electrode is filled with a concentrated electrolyte (3MKCl) which serves as a conductor while the glass tube serves as an insulator. Since the microelectrode itself has a high capacity and electrical resistance (10 to 60 megohms) the need for an input-capacity neutralization is a prerequisite. Furthermore, in studies lasting over a long period of time, low drift direct-coupled amplifiers are required. Thus, when the intracellular microelectrode is properly paired with an appropriate reference electrode (Ag-AgCl) placed in the perfusion fluid, individual myocardial cells may be penetrated and the electrical activity directly transcribed via recording devices which are capable of high frequency response. The electrical activity of the single myocardial cell, thus recorded, constitutes the monophasic action potential (AP), from

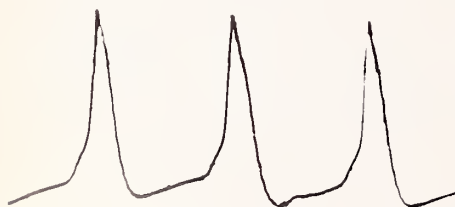


FIGURE 1

SINOATRIAL cell action potentials of a rabbit heart. Note that there is no true resting potential but that following repolarization there is a continuous slow diastolic depolarization which on reaching its threshold potential fires off in a self sustaining manner. (These action potentials as well as those depicted in Figures 2-9 were recorded in the electrophysiology laboratories of the Krannert Institute of Cardiology.)

which the clinical electrocardiogram is ultimately derived. And each type of cardiac tissue (SA nodal, atrial, AV nodal, His-Purkinje, and ventricular) exhibits a characteristic, identifiable AP configuration, as shown in Figures 1-5.

Advantages

The advantages of this microelectrophysiologic technic are several and the information to be derived is substantial. In particular, such direct recordings permit assessment of the individual cell's electrical behavior and thereby provide information that may not be discernible from the clinical ECG. For there are two basic types of myocardial cells: the contractile type, including atrial and ventricular cells; and the specialized conduction tissue, including the SA node and AV node, and His-Purkinje system, the cells of which possess the latent or overt capacity to initiate impulses spontaneously. The clinical



FIGURE 2

SINGLE contractile fiber action potential of canine atrium. Note in contrast to AP in Figure 1 the steady resting potential (phase 4), the rapid depolarization (phase 0) with a prominent overshoot (phase 1) and the rapid phase of repolarization. Atrial contractile cells show a less developed plateau or phase 2 (see Figure 4 and 5 for comparison with myocardial and Purkinje cell).



FIGURE 3

TRANSMEMBRANE action potentials recorded from single fibers located in the upper to mid-portion of the atrioventricular node of a canine heart. Its configuration is very similar to that obtained from sinoatrial cells.

ECG, moreover, reflects the activity of these various cell types to a varying degree. The "p" wave, e.g., may be considered to reflect atrial cell depolarization, while ventricular cell activity is manifested by the electrocardiographic QRS. The specialized conduction tissue however, comprises too small a mass to be directly reflected on the ECG, and its effects are apparent only indirectly, via changes in rhythm, rate, and apparent conduction-velocity. As a consequence, the externally recorded ECG may be described as a relatively insensitive index of electrophysiologic phenomena, recording only the net result of a host of intricate, interrelated physiologic events.

Cardiac arrhythmias, e.g., may be elicited by a variety of electrophysiologic events, including enhanced impulse formation, a reduction in

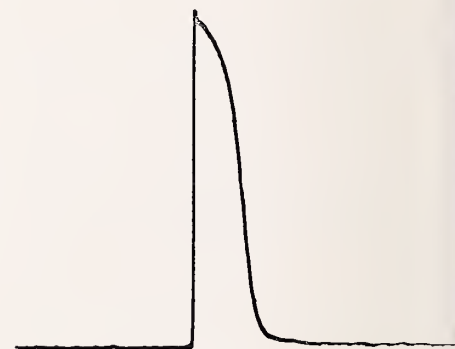


FIGURE 4

TRANSMEMBRANE action potential of pig ventricle. Note the difference in the duration of the action potential as compared to the atrial type (Figure 3) and is a result of the more prolonged phase 2 or plateau.



FIGURE 5

TRANSMEMBRANE action potential of a Purkinje fiber recorded from a pig heart. The plateau or phase 2 is most marked in these specialized conducting fibers.

transmembrane resting potential, a reduction in myocardial stimulus threshold, and a depression of conduction velocity. Yet, the routine ECG does not discriminate among these predisposing factors and, as a result, provides relatively little information concerning the genesis of arrhythmia. Microelectrophysiologic study, however, permits a direct assessment of the effects of drug, electrolyte, and other environmental alterations upon the various electrophysiologic properties of the cardiac tissues. Thus, a more objective definition is provided of the circumstances giving rise to cardiac arrhythmias, and an opportunity is provided to evaluate directly the properties of antiarrhythmic agents. In this manner, more objective and hence more effective antiarrhythmic therapy may be developed.

Contractile Properties of the Heart

In addition to the above described electrophysiologic study of arrhythmia-formation and impulse conduction, studies involving the contractile properties of the heart are being done at the Krannert Institute of Cardiology. The technic of recording myocardial contractile force involves the utilization of an extremely sensitive tension transducer. Since the simultaneous recording of tension and AP's are to be accomplished, it is important to arrange the tissue in the perfusion bath in a manner compatible with sustaining the viability of the cells as well as making both types of recording feasible. Hence a section of the myocardium is removed so that it contains a fine papillary or trabecular muscle (0.5 to 1 mm in diameter). The entire tissue section is immersed in a 30 ml chamber perfused with oxygenated Tyrode solution and clamped or pinned to a plastic block situated at the base of the chamber.

One end of the thin muscle is freed from its attachments and impaled by a fine steel hook suspended

from a gold chain. The gold chain is preferred to string since the latter on exposure to air will dry and shrink, thereby changing the length-tension relationship of the muscle which is to be avoided in isometric recording of muscle tension. The gold chain in turn is connected to a special transducing cell (Statham Universal Cell Model UC3) that detects the development of myocardial force which is transduced by oscillographic and/or photographic units. The muscle tissue itself is permitted to contract by driving it with appropriate stimuli administered by bipolar chemically inert (stainless steel, platinum, etc.) wire electrodes (0.005 inch diameter). For a more detailed analysis of the concepts and definition of cardiac contractility and inotropy, the reader is referred to a recent review by the co-authors.²¹

Utilizing the above described tech-

niques, investigators at the Krannert Institute have discerned a relationship between the configuration of the myocardial AP and the contractile properties of the myocardium, a relationship that had not been hitherto appreciated. That is, prior investigators had either overlooked or dismissed as inconsequential AP changes that were noted in a temporal relation to contractile enhancement. A series of studies at the Krannert microelectrophysiology laboratory have shown, however, that interval-dependent contractile enhancement (i. e., contractile enhancement that occurs as a consequence of, or in relation to, abrupt rate change, such as post-extrasystolic potentiation, post-stimulation potentiation, and rest potentiation) are consistently associated with a characteristic alteration of the accompanying AP (as shown in Figures 6-9). It has also been shown

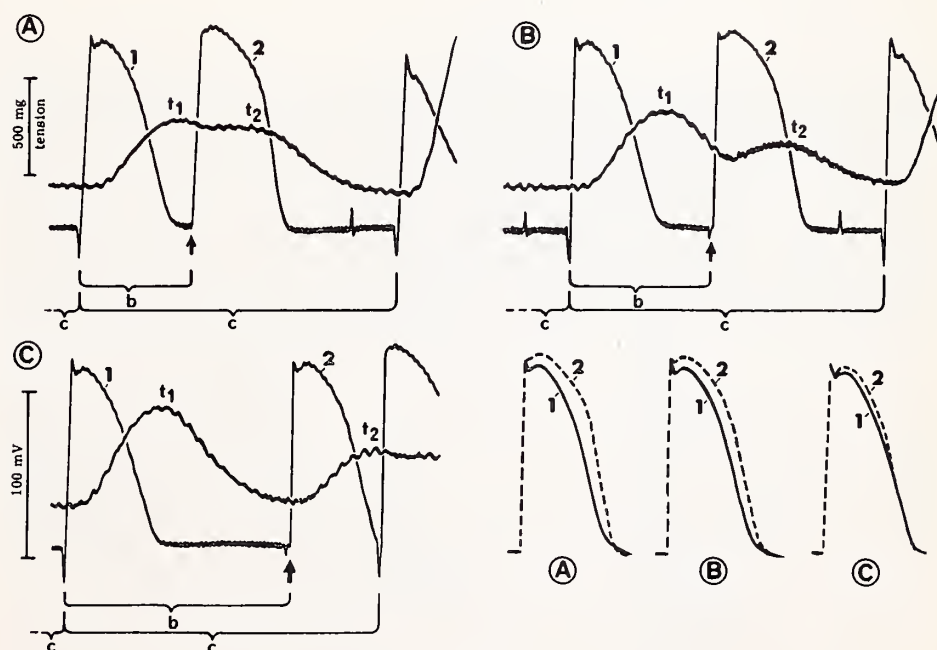


FIGURE 6

ACTION potentials (AP) and contractile tension (t) associated with "extrasystoles" (marked by arrows) were initiated at different intervals after the regularly stimulated events (labeled 1 and t_1). The dominant cycle-length is labeled c. In panels A, B, C, the premature AP and developed tension (labeled 2 and t_2) follow intervals (labeled b) which are shorter than interval c. In each case, the premature AP exhibits a longer phase 2 and is associated with a weakened contraction. In panel A, the premature stimulus follows the shortest cycle-length with respect to interval c and elicits the weakest contraction and an AP with the longest phase 2. In panel C, the premature stimulus follows the longest interval (i.e., it is the least premature stimulus) and the associated AP exhibits the least phase 2 widening and is accompanied by the most forceful of the premature contractions. In panel B, the stimulus is of intermediate prematurity, associated with a contraction of intermediate strength and an AP with a phase 2 of intermediate length. The AP differences are illustrated by superimposition in the lower right panel; the configurations of the action potentials marked 1 in A, B, and C are identical. (From Greenspan, K., et al: *Circ. Res.* 20:311, 1966: by permission of the American Heart Association, Inc., New York).

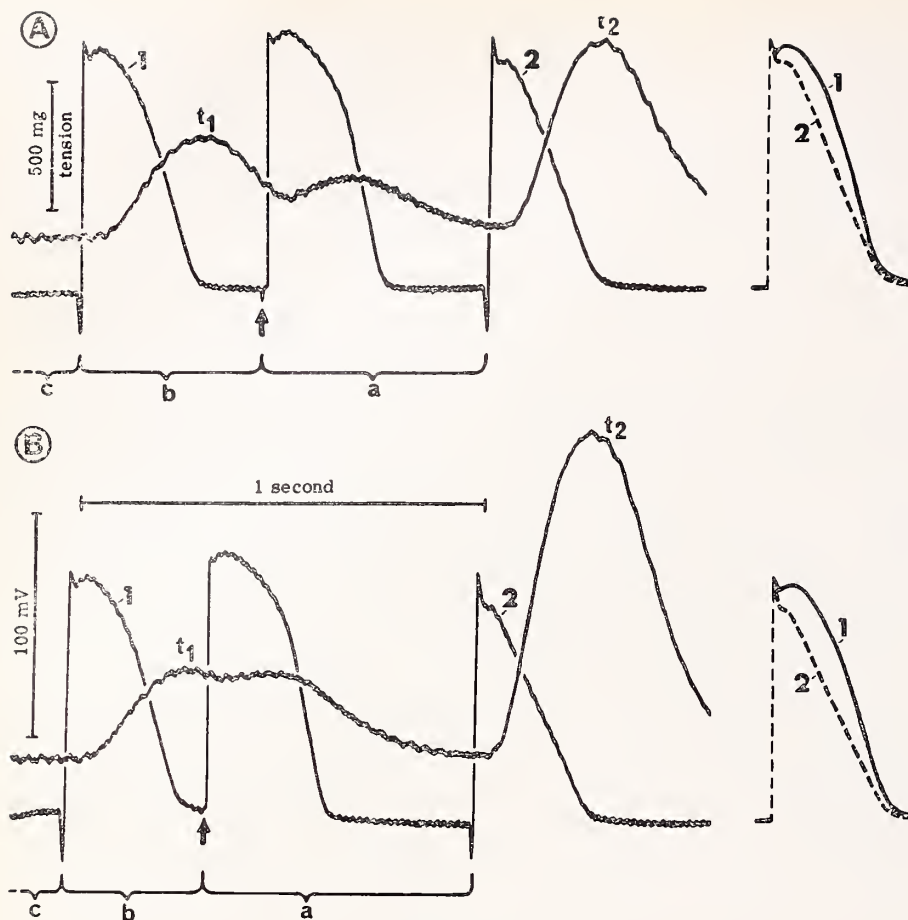


FIGURE 7

POST-EXTRASYSTOLIC beats exhibited a more forceful contraction when preceded by an early premature contraction. The associated action potentials show an abbreviated phase 2 and prolonged phase 3. In each panel, the post-extrasystolic beat occurs after a cycle-length that is prolonged relative to the preceding interval (interval a is greater than interval b). In panel B, both a more forceful contraction and an AP with a shorter phase 2 are associated with a greater prolongation of the cycle-length (i.e., a greater ratio of interval a/interval b). This should be compared with Figure 6 in which a smaller ratio (interval b/interval c) is associated with a wider phase 2 of the AP and with a less forceful contraction. Superimposition of the action potentials is shown at the right of each tracing. (From Greenspan, K., et al: *Circ. Res.* 20:311, 1966: by permission of the American Heart Association, Inc., New York).

that depression of contractile force (in the premature beat, e.g.) is associated with an AP alteration that is quite the reverse of that which accompanies contractile enhancement. Further studies have demonstrated an identical AP alteration in association with the inotropic effect of both digitalis and nicotine.^{22,23}

These studies have been performed upon isolated segments of ventricular muscle, from human hearts as well as from the experimental animal. Contractions were recorded isometrically (i.e., the muscles exerted tension, upon stimulation, without shortening), while action potentials were recorded simultaneously via an intracellular microelectrode. As the contractions were isometric, the contribution of length variation (i.e., the Frank-Starling relation) was excluded, and the variations in contractile strength could therefore be attributed to alteration in the inherent speed of contractile shortening of inotropic state. Furthermore, the type of AP change that has been associated with inotropic enhancement is readily explicable²⁴ on the basis of increased K⁺ efflux from the cell,

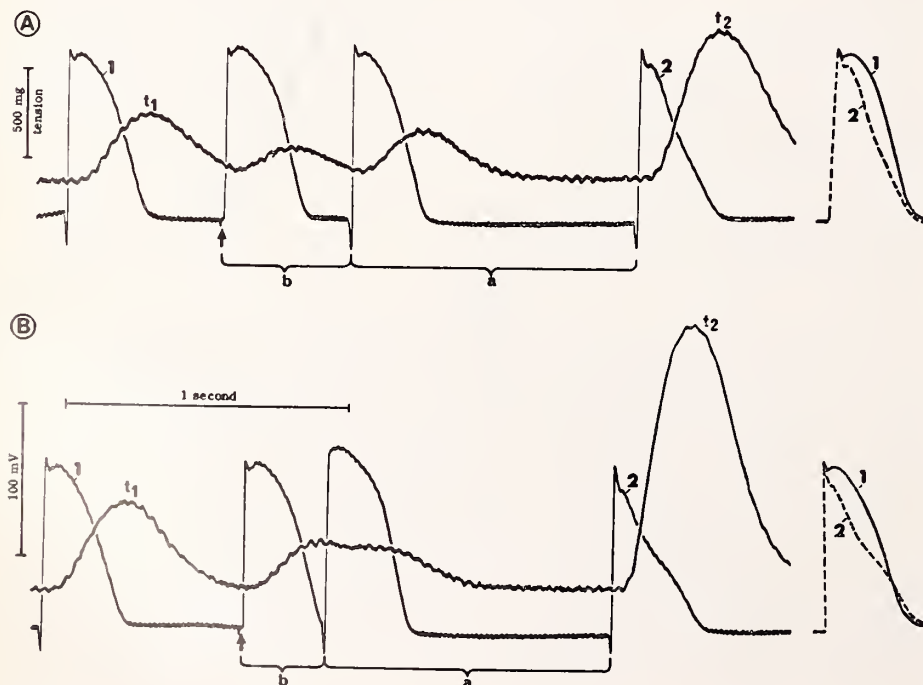


FIGURE 8

TRACINGS A and B illustrate extrasystoles (marked by arrow) interpolated in diastole. In such cases it is the second beat (following interval a) after the extrasystole which shows contractile potentiation (t₂) and phase 2 abbreviation (AP #2). This is further illustrated by superimposition of the action potentials at the right of each tracing. The first contraction and AP after interval b, following the extrasystole, in contrast, is not enhanced with respect to the control (AP #1, and t₁). Again, there is a relation between the extent of contractile and AP change and the magnitude of interval a/interval b. (From Greenspan, K., et al: *Circ. Res.* 20:311, 1966: by permission of the American Heart Association, Inc., New York).

and some observers^{25,26} have related contractile enhancement (i.e., positive inotropy) to a net loss of K^+ from the myocardial cell. Thus, an electrophysiologic correlate of the inotropic state of the myocardium appears to have been identified, although substantial work remains in order to determine the consistency and uniformity of this electrophysiologic finding with all types of inotropic enhancement. If such proves to be the case, however, further insight will have been gained into the nature of the inotropic response itself.

This brief review of the activities of the electrophysiology department (Figure 10) of the Krannert Institute of Cardiology illustrates our principle areas of endeavor in this discipline. These activities are of particular importance as they help to clarify the mechanisms of cardiac arrhythmia formation and conduction disturbances providing a framework within which current drug therapy may be objectively tested, and further therapy may be formulated. More basic studies, delineating the electrophysiologic aspects of cardiac inotropy, may help to elucidate the nature of the contractile response itself.

(A copy of the references pertaining to this paper may be obtained by writing The Journal office.)

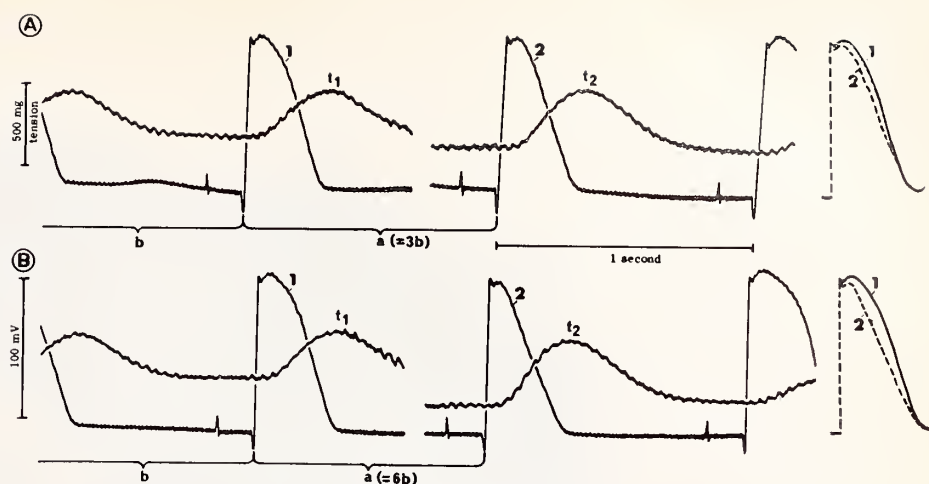


FIGURE 9

SIMULTANEOUS recording of action potentials and contractile tension, interrupted by the omission of a variable number of stimuli. As in the prior illustrations, a more marked prolongation of the cycle-length is associated both with a greater potentiation of contractile force and with an AP bearing a greater shortening of phase 2. This relation is further illustrated by superimposition at the right of the tracing. (From Greenspan, K., et al: *Circ. Res.* 20:311, 1966: by permission of the American Heart Association, Inc., New York).



FIGURE 10

ELECTROPHYSIOLOGIC laboratory.



"George wants to know if it's okay to take his cold medicine now, Doctor, instead of seven o'clock?"



The long-continued action of Novahistine LP should help you both get a good night's sleep. Two tablets in the morning and two in the evening will usually provide round-the-clock relief by helping clear congested air passages for freer breathing. Novahistine LP also helps restore normal mucus secretion and ciliary activity—normal physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains: phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odlum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

William E. Reynolds, M.D.
Medical Director

A Building Block approach to treating hypertension



With these three therapeutic building blocks you can create a once-a-day regimen to fit almost any degree of hypertension. See the following pages for details . . .



Consider starting your hypertensives on this basic thiazide



A single daily dose of Enduron provides sodium excretion around the clock





Enduron is a true 24-hour single-dose thiazide. Its sodium excretion is not squeezed into an abrupt peak during the first several hours. It is well-sustained in a plateau-like effect—with little reduction for the first 12 hours, and decline thereafter only gradual.

Potassium loss, by contrast, is low. It reaches an early minor peak, then subsides rapidly. Moreover, since dosage is but once a day, there is but one daily peak of potassium loss. As with all thiazides, however, dietary potassium supplementation should also be considered, especially in long or intensive therapy.

Use Enduron as an ideal starting therapy in mild hypertension. Use it too, as a basic therapeutic building block with which other agents can be joined, for managing your more resistant hypertensives.

Once a day, every day
ENDURON®
METHYCHLOTHIAZIDE



DAILY DOSAGE RANGE	Minimum	Usual	Intermediate	Maximum
				
	2.5 mg. tablet	5 mg. tablet	7.5 mg.	10 mg.

See Brief Summary on final page of advertisement.

To build added response, shift to Enduronyl



The deserpidine component adds enhanced antihypertensive activity

The rauwolfia component of Enduronyl is deserpidine (Harmony[®]), a purified crystalline alkaloid supplied only by Abbott. It augments Enduron with its own antihypertensive and tranquilizing action.

Thus the combined clinical effect of these two therapeutic building blocks in Enduronyl is greater than can ordinarily be achieved with either alone.

To add flexibility, Enduronyl comes in two strengths: regular and Forte. Both provide 5 mg. of Enduron. The variation is where most helpful: in the deserpidine. The tablets are scored, and give a surprisingly wide and economical choice of once-a-day doses (see below).

Choose Enduronyl for your patients in the broad range of mild to moderate hypertension. Patient acceptance is excellent!

Once a day, every day









ENDURONYL[®]

METHYCHLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.25 MG.

ENDURONYL FORTE

METHYCHLOTHIAZIDE 5 MG. WITH DESERPIDINE 0.5 MG.



	Minimum	Usual	Intermediate	Maximum
DAILY DOSAGE RANGE	 2.5 mg. methyclothiazide 0.125 mg. deserpidine	 5 mg. methyclothiazide 0.25 mg. deserpidine	 7.5 mg. methyclothiazide 0.375 mg. deserpidine	 10 mg. methyclothiazide 0.5 mg. deserpidine
DAILY DOSAGE RANGE	 2.5 mg. methyclothiazide 0.25 mg. deserpidine	 5 mg. methyclothiazide 0.5 mg. deserpidine	 7.5 mg. methyclothiazide 0.75 mg. deserpidine	 10 mg. methyclothiazide 1 mg. deserpidine

See Brief Summary on final page of advertisement.

Eutonyl affords a different kind of basic therapy for moderate to severe cases



Effect tied to reduced peripheral vascular resistance; no central depressant action

Eutonyl is a unique nonhydrazine agent. It is reported to act by reducing peripheral vascular resistance.^{1,2}

In clinical trials, significant reductions in mean blood pressure were seen in 84% of patients studied—all were moderate to severe cases. Eutonyl lowers diastolic in proportion to systolic, and in about half of the cases studied, reductions in the sitting and recumbent positions were nearly as great as in the standing position.





Most important: There is no central depressant action. In fact, some patients reported an *increased* sense of well being.

Here, then, is a highly effective *basic treatment* for moderate to severe cases—and one that will not hamper your patient with lethargy or drowsiness while on treatment.

Once a day, every day

EUTONYL®
PARGYLINE HYDROCHLORIDE



DAILY DOSAGE RANGE	Minimum	Usual starting	Intermediate	Maximum
				
	10 mg. tablet	25 mg. tablet	50 mg. tablet or as needed	200 mg.

1. Brest, A. N., et al., Cardiac and Renal Hemodynamic Response to Pargyline, Ann. N. Y. Acad. Sci., 107-1016, 1963.
2. Winsor, T., Pargyline Hydrochloride, Hypertension, Urinary Tryptamine, and Vascular Reflexes, Geriatrics, 19:598, Aug., 1964.

See Brief Summary on final page of advertisement.

AMA '67 HOUSTON

AMA 21ST CLINICAL CONVENTION • ASTROHALL • HOUSTON, TEXAS • NOVEMBER 26-29, 1967

Plan to attend this year's AMA Clinical Convention in Houston, Texas. Eighteen scientific sessions, four postgraduate courses, breakfast roundtable discussions, color television, and scientific and industrial exhibits will bring you up to date on the latest medical advances. Attend lectures by, and discussions with, our nation's outstanding medical authorities.

Between sessions, enjoy the excellent restaurants, fine shops, visitors' attractions, and mild winter temperatures Houston offers. Mail the enclosed registration and room reservation coupons now, and look forward to an exceptional convention with a holiday plus.

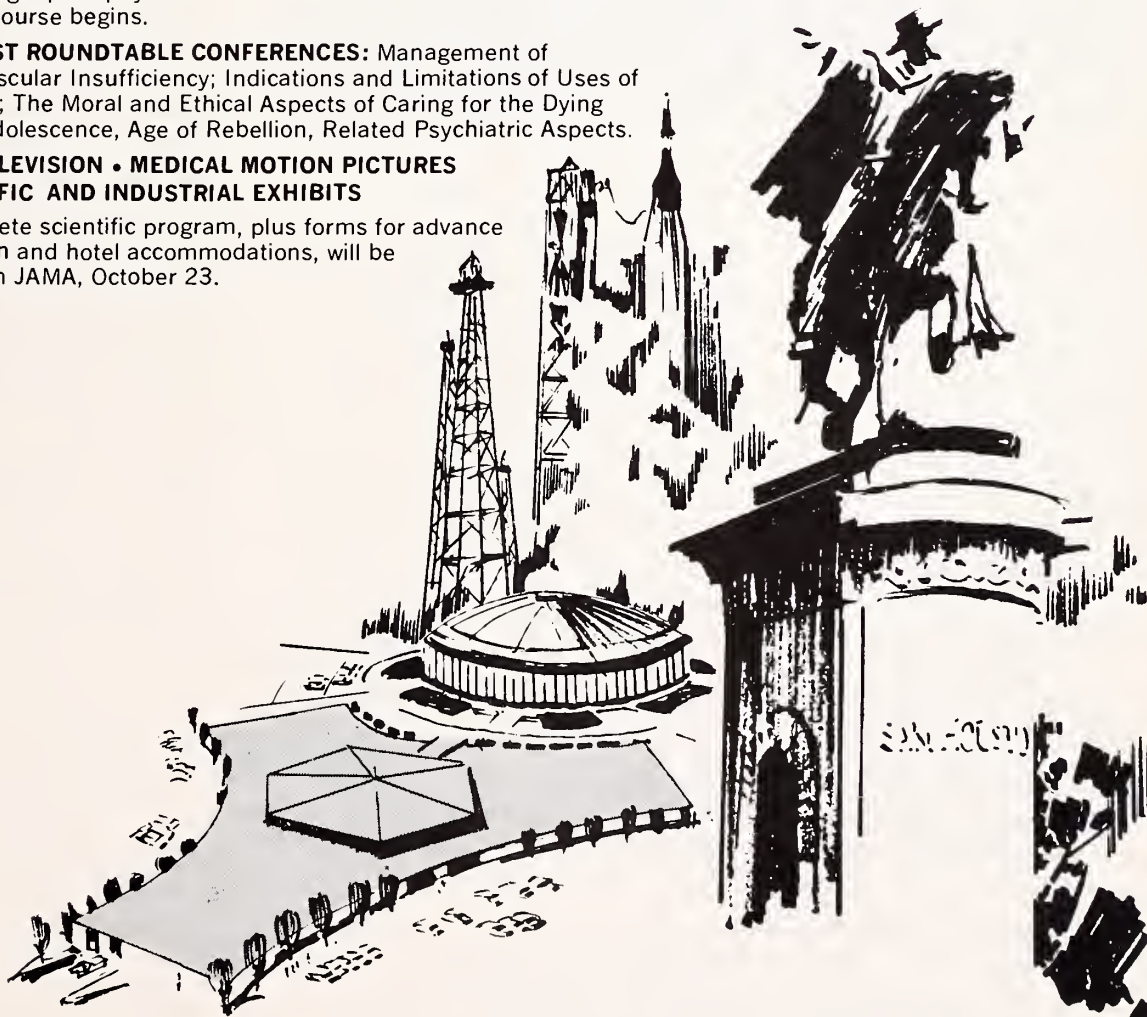
SCIENTIFIC SESSIONS: Cardiovascular Disease; Cardiovascular Surgery; New Cares; Ophthalmology; Geriatrics; Arthritis; Gastroenterology; Cancer; Antibiotics; Endocrinology; General Surgery; Dermatology; Aerospace Medicine; Obstetrics and Gynecology; Psychiatry; Pediatrics; Genitourinary Diseases; and Otolaryngology.

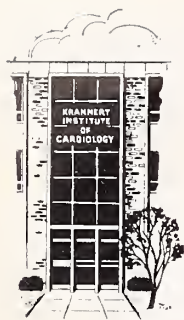
POSTGRADUATE COURSES: Fluid and Electrolyte Balance; Oncology; Cardiovascular Disease; and Obstetrics and Gynecology. Register for these Courses on arrival in Houston at the PG Course Registration booth adjacent to the General Registration area. There is no charge for the Courses, but registration is limited to 200 per Course. The Courses begin promptly at 9 A.M. and 2 P.M. No one will be seated after the Course begins.

BREAKFAST ROUNDTABLE CONFERENCES: Management of Cerebrovascular Insufficiency; Indications and Limitations of Uses of Antibiotics; The Moral and Ethical Aspects of Caring for the Dying Patient; Adolescence, Age of Rebellion, Related Psychiatric Aspects.

**COLOR TELEVISION • MEDICAL MOTION PICTURES
• SCIENTIFIC AND INDUSTRIAL EXHIBITS**

The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, October 23.





Exercise Laboratory

JOHN W. JORDAN, M.D.

EXERCISE TESTING can provide objective evaluation of cardiovascular function in terms of work capacity while simultaneous electrocardiographic recordings offer indirect information concerning the adequacy of the coronary circulation's response to increased metabolic requirements. The usefulness of post-exercise electrocardiographic data for detection of ischemic coronary disease and subsequent prognosis has been carefully documented.¹ Despite interpretative limitations, epidemiological studies showing an increased incidence of ischemic coronary disease among sedentary workers as compared to their physically active colleagues² has aroused interest in the prophylactic and rehabilitative therapeutic possibilities of regular physical exercise.⁶

Tests involving physical exercise may be classified as submaximal effort tests and maximal aerobic capacity tests. Submaximal effort tests set a predetermined endpoint in terms of work load or physiological sign and thereby measure the subject's response to a particular amount of work. Tests of maximal aerobic work capacity permit the subject to exercise to maximum capacity within a short interval of time without a pre-set endpoint. Maximal work capacity testing thus provides a relative basis for comparing individuals in terms of stress severity expressed as a percentage of each subject's maximum capacity. Evaluation of a regular physical exercise program would require such a relative comparison scale for determining at what level of stress severity any significant

effect was noted.

Standardized Conditions

In both submaximal and maximal exercise capacity tests, the simultaneous measurement of oxygen uptake rate provides an objective indication of the severity of metabolic stress achieved; blood lactate concentration has also been used. Heart rate at submaximal work loads is influenced by too many variables to be considered a reliable indicator of stress severity. As an expression of exertional capacity, oxygen uptake is better correlated with circulation and tissue per time and mass units (ml/kg/min) than expressed as total oxygen uptake for the whole body per time unit.³ Genetic factors, age, sex, air temperature, air oxygen concentration and type of exercise are some of the recognized determinants of an individual's maximal oxygen uptake; this variety of influencing factors indicates the importance of maintaining standardized conditions during every test. In some circumstances an individual's exercise performance capacity may be diminished without reduction in his maximal oxygen uptake;⁴ measurement of oxygen consumption during exercise testing thus acquires added potential significance. Supramaximal work loads used for documentation of true maximal oxygen intake in the developmental research of this concept are not feasible for clinical application.

Reports comparing post-exercise electrocardiographic signs of ischemic coronary disease in asymptomatic subjects undergoing both submaximal and maximal effort capacity testing

indicate a significantly greater incidence of positive responses after maximal effort testing.³ Adaptation of electronic computer technology has made possible the objective analysis of electrocardiograms recorded during active physical exercise⁵ thus providing a possible means for earlier pre-symptomatic diagnosis of latent ischemic coronary disease.

The type of exercise used in circulatory stress testing should involve as large a proportion of the body muscle mass as possible in order to stress the circulatory system maximally. The training or skill required to perform the exercise should be minimal so that the test is applicable to the widest variety of individuals. Running has been found to be a fairly basic form of exercise which also involves the whole body weight in the work load; this is an important consideration when interpreting oxygen uptake measurements. For producing greater stress (maximal oxygen uptake) and for reducing the skill requirement factor, a treadmill offers advantages compared to a bicycle ergometer.^{3,4} The significance of submaximal exercise for warming-up prior to maximal exertion is still debated, but the necessity for allowing sufficient time in each successive work load to achieve steady-state conditions before taking measurements is recognized.

Although consideration of exercise testing here has been focused on the cardiovascular system, the simultaneous involvement of respiratory, skeletal and neuromuscular systems points up the need of careful clinical inquiry and physical examination prior to any form of exercise testing for the subject's protection as well as for logical interpretation of test results. Attentive clinical observation for signs of physical exhaustion or other physical deterioration as well as continuous monitoring of the electrocardiogram are important considerations for the subject's well-being during an exercise test.

The exercise study laboratory at the Krannert Institute of Cardiology (Figure 1) has been equipped with a treadmill capable of variable speed and grade. Electronic sensing devices provide rapid analysis of oxygen and carbon dioxide content in the exercising subject's expired air; this data is recorded on magnetic tape simultaneously with the electrocardiographic signal from direct leads on the exercising subject. Facilities of the electronic computer center at the Indiana University Medical Center offer a means for rapid analysis of the magnetically recorded data.

REFERENCES

1. Robb, G. P., Marks, H. H.: Latent coronary artery disease; determination of its presence and severity by the exercise electrocardiogram, *Am. J. Cardiol.* 13:603, 1964.
2. Fox, S. M., Skinner, J. S.: Physical activity and cardiovascular health, *Am. J. Cardiol.* 14:731, 1964.
3. Bruce, R. A., Rowell, L. B., Blackmon, J. R., Doan, A.: Cardiovascular function tests, *Heart Bulletin* 14:9, 1965.
4. Astrand, P. O.: Aerobic work capacity during maximal performance under various conditions, Suppl. I, *Circ. Res.* XX:1202-1210, 1967.
5. Bruce, R. A., Mazzealla, J. A., Jordan, J. W., Green, E.: Quantitation of QRS and ST segment responses to exercise, *Am. Heart J.* 71:455, 1966.
6. Naughton, J., Balke, B., Nagel, F.: Refinements in method of evaluation and physical conditioning before and after myocardial infarction, *Am. J. Cardiol.* 14:837, 1964.

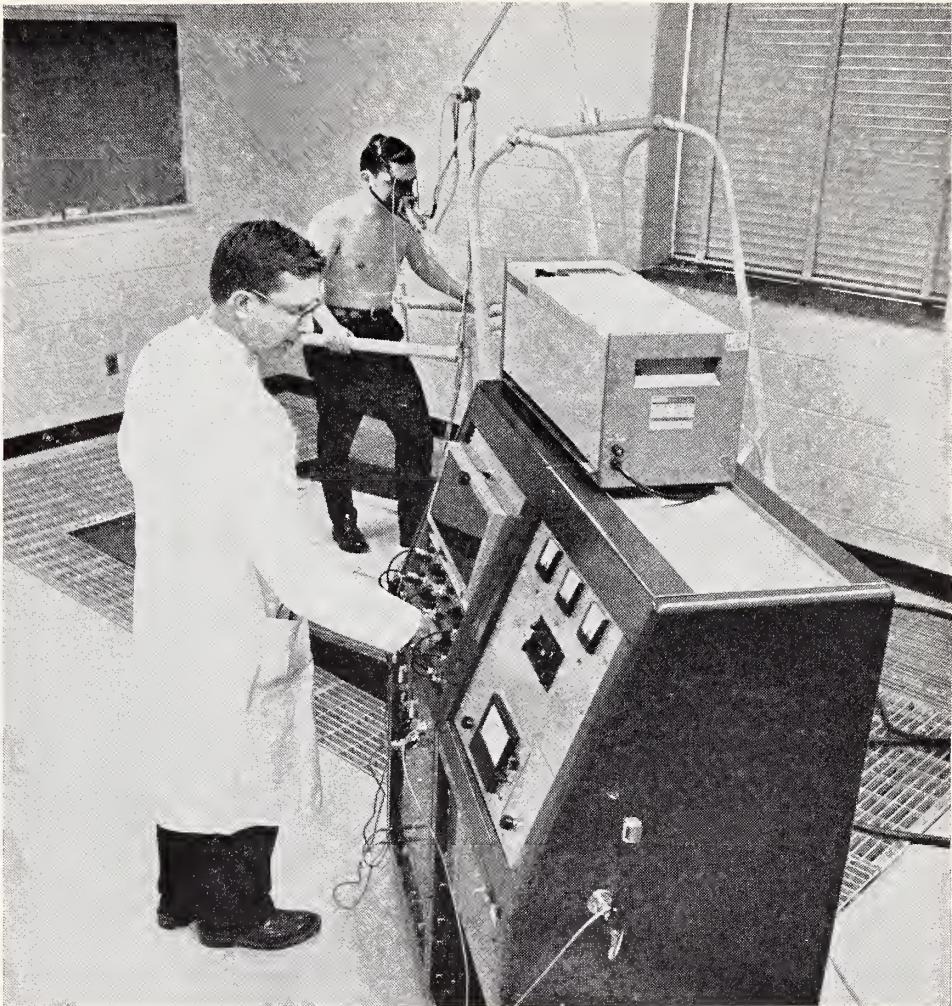


FIGURE 1
THE exercise laboratory at the Krannert Institute of Cardiology.

INDIANA UNIVERSITY SCHOOL OF MEDICINE LIBRARY
TELETYPE SERVICE

Physicians in over 140 Indiana communities outside of Marion County who do not have direct access to the library may request specific references or bibliographic searches from the Indiana University School of Medicine Library by merely calling their local public libraries and asking that the request be placed by TWX. There is no charge for the teletype call.

Xeroxed copies of the first 20 pages of any one article are gratis. If an article is over 20 pages, a ten cent charge is made for each additional exposure.

For further information write to: Indiana University, School of Medicine Library, Reference Department, 1100 W. Michigan St., Indianapolis, Indiana 46207.

This is the sixth in a series of articles describing the cancer program in Indiana as supported by the American Cancer Society. The vital need for an effective therapy for the many different types of neoplastic diseases depends on progress made both at the bedside by the clinician and in the laboratory by the investigator. The advance in the fight against cancer is closely tied together with our understanding of the control of the functions of normal cells.

Malformations in Plants Caused by a Mold Product, Malformin

IN 1958 Professor R. W. Curtis discovered at Purdue University that a black mold, *Aspergillus niger*, produced an extremely active substance which caused malformations in plants. The compound, named malformin, causes curvatures and grotesque malformations on bean plants three to ten days after the apical bud has been treated. In addition, elongation of the internodes is severely inhibited. Malformations have consisted of greatly thickened stems and petioles, irregular



stem protrusions, severely twisted stems and petioles, and stems that are wide and relatively flat. Subsequently, it was shown that culture filtrates of *A. niger* also induced curvatures on corn roots. Evidence obtained by paper chromatography indicated that the compounds active on bean stems and on corn roots were identical.

The histology of the irregular stem enlargements induced by malformin indicated that the malformations resulted from an apparent partial loss of polarity of the cells in the actively growing region of young internodes and petioles. That is, many of the cells were oriented at right angles to

the normal orientation. These findings raised an interesting question. Is it now possible that in addition to substances which induce cell elongation and cell division, a new material is available which influences the polarity or arrangement of developing cells? If so, does malformin interfere with such regulators within the plant?

More recently malformin was isolated from culture filtrates of *A. niger* and shown to be a cyclic peptide containing cysteine, valine, leucine and isoleucine in a molar ratio of 2:1:1:1, respectively. The molecular formula $C_{23}H_{41}O_5N_5S_2$ was proposed. In addition, evidence was obtained which indicated the possibility of a second malformin which contains allo-isoleucine. An interesting observation concerning the structure of malformin centers about the unusually high content of the sulfhydryl amino acid, cysteine. The high cysteine content of malformin (40%) is not exceeded by other naturally occurring compounds.

Isolation of malformin made it possible to test this remarkable compound quantitatively. These studies have shown malformin to be one of the most active growth regulators available. When used to treat stem tips of bean or corn root tips, malformin has been detected when as little as 1×10^{-4} micrograms per plant were applied.

Corn root curvatures induced by malformin are striking. It is not

unusual for the roots to form "figure-eights", "corkscrews", and in many cases, the roots actually tie themselves into knots! Treatment of various portions of the root showed that the root tip is the responding region.

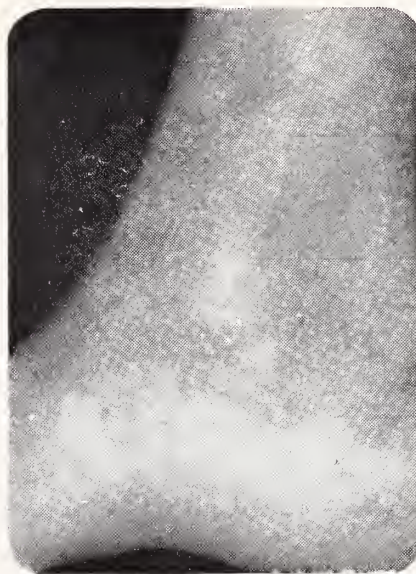
A further interesting feature of malformin is an apparent unusual relationship which exists in the response of various plants and plant parts. Malformin was readily shown to be effective on the stems of a number of dicotyledonous plants and is very active on the root of a monocot (corn). However, attempts to demonstrate activity on the roots of dicots have failed, and only with difficulty was it shown to have slight activity on the stem of the monocot.

Because of the difficulty in obtaining sufficient quantities of malformin, experimental work with animals has been limited. However, preliminary work has shown malformin to be toxic to the rat and to arrest development of insects in low concentrations. Professor Curtis has obtained evidence which suggests that, in plants, the compound stimulates ethylene production. Ethylene is a plant growth regulator active in minute quantities which has recently been shown to be produced in the liver of rats. Studies are underway to learn more about the chemistry and mode of action of this unusual compound. This research is being supported by a grant from the American Cancer Society. ◀

Eczema of many years... controlled in two weeks



Before treatment



After treatment —
with ARISTOCORT Topical
Ointment 0.1% for two weeks

ARISTOCORT® Triamcinolone Acetonide Topicals have proved exceptionally effective in the control of various forms of eczema: allergic, atopic, nummular, psoriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, the 0.1% concentration is sufficiently potent. The 0.5% concentration provides enhanced topical activity for patients requiring additional potency for proper relief.

Administration and Dosage: Apply sparingly to the affected area 3 or 4 times daily. Some cases of psoriasis may be more effectively treated if the 0.1% Cream or Ointment is applied under an occlusive dressing.

Contraindications: Tuberculosis of the skin, herpes simplex, chicken pox and vaccinia.

Precautions and Side Effects: Do not use in the eyes or in the ear (if drum is perforated). A few individuals react unfavorably under certain conditions. If side

effects are encountered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyoderma will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Available in 5 Gm. and 15 Gm. tubes and ½ lb. jars.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort®

Topical Ointment 0.1% and Cream 0.1%, 0.5%
Triamcinolone Acetonide

Also available in foam form.



LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

406-6

X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

Arteriographic Assessment of Internal Mammary Lymph Node Metastases

ERICH K. LANG, M.D.
Indianapolis*

A 37-year-old white female was referred for assessment of metastatic disease to the internal mammary nodes, and the feasibility of radical surgical intervention.

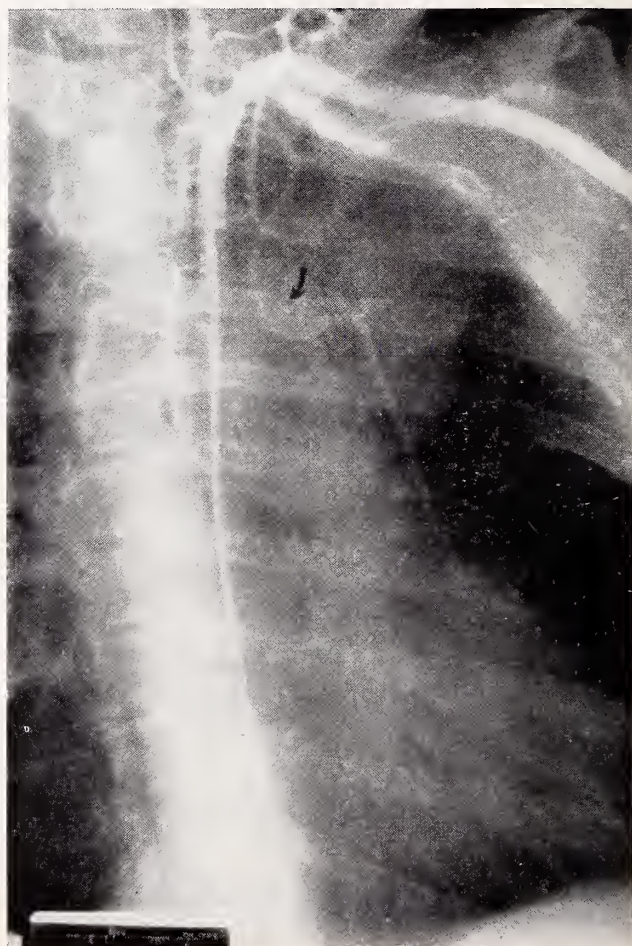
Some nine months prior, the patient had been subjected to a radical mastectomy for carcinoma of the breast, located in the upper medial quadrant of the left breast. At the time of resection, skin invasion was demonstrated. The tumor mass was fixed to the pectoralis muscle, however the surgeon felt confident that a clear cleavage line of the tumor against the anterior chest wall itself had been established. Seventeen of the axillary lymph nodes showed extensive metastatic involvement, including all of the apical lymph nodes. The patient was subjected to a course of postoperative radiation therapy, consisting of supraclavicular fields, an axillary field and tangential fields to the anterior chest wall. The supraclavicular area was carried to a dosage of 3,750 reps; the axillary field was carried to a dosage of 4,000 reps and the anterior chest wall was given a dosage of 3,000 reps calculated at a depth of two cms., with rice bolus interposed to insure homogeneous irradiation.

Recent chest roentgenograms suggested slight widening of the superior mediastinum. Fluoroscopy and oblique films confirmed the suspicion, however, a definite mass lesion could not be demonstrated. Laminograms through the superior mediastinum

were obtained, but apart from slight widening, failed to show any evidence of a mass lesion. A left venogram and superior vena cavogram failed to demonstrate obstruction or obvious displacement. For confirmation of the diagnosis of metastatic involve-

FIGURE 1

THE arteriogram demonstrates marked displacement and splaying of the left internal mammary artery around a mass lesion. The sharp localized deviation of the artery suggests that the mass originated from the internal mammary nodes, and is in close apposition to the pathway of the internal mammary artery.



*Radiologist, Methodist Hospital, Indianapolis 46207.

ment of the internal mammary nodes, a pneumomediastinum or internal mammary arteriogram was suggested. The latter examination was favored because of the great ease and safety of this procedure.

The left subclavian artery was selectively injected, and the left internal mammary artery was well visualized. A marked displacement of the internal mammary artery around a huge mass, measuring more than three cms. in cross diameter, confirmed the presence of nodular lymph node masses in the internal mammary chain (Figure 1).

Mediastinoscopy was performed, and confirmed the presence of the

nodular masses, undoubtedly representing metastatic disease to the internal mammary nodes. In view of these findings, and the poor general condition of the patient, further plans for radical surgery were cancelled. Massive pleural effusions and rapid dissemination of metastatic disease necessitated a hypophysectomy some three months later. The patient succumbed to the disease within five months.

Discussion

Arteriographic demonstration of the internal mammary artery offers an excellent and reliable tool for assessment of masses in the internal mammary nodes. Diagnostic assessment of these elusive structures often

dictates the mode of therapy of carcinoma of the breast. The described method is simple, and allows definitive assessment on basis of displacement of the artery by any masses in the lymph node chain. Diagnostic pneumomediastinum can be utilized for the same purpose, and may demonstrate lymph node masses if satisfactory dissection can be carried out in this plane. Lymphangiography has been universally disappointing in this area. Venography, likewise, will only demonstrate abnormalities in the presence of massive disease. Mediastinoscopy is recommended for confirmation of the diagnosis, suggested on arteriograms. ◀

Share Your Medical Journals With Colleagues Overseas

The doctors of the U.S.A. are being asked to send their medical journals—after they have read them — to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (*particularly specialty journals*), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your cooperation in this program will be greatly appreciated and your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, M.D., Director, c/o The World Medical Association, Inc., 10 Columbus Circle, New York, New York 10019.

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

Dislocation of the Hip with Femoral Shaft Fracture

ALOIS E. GIBSON, M.D.
Richmond

*I*N this era of high speed transportation, multiple and severe injury cases are seen with increasing frequency in hospital emergency rooms. Physicians treating this high speed trauma must be aware of various syndromes and combination injuries so that optimal treatment may be rendered the accident victim.

One of these areas of increasing multiple injury is the femur and hip joint. Recent literature reveals an increasing number of reports of fractures of the femoral neck accompanying femoral shaft fractures. Another, but less common multiple injury in this area, is the fracture of the femoral shaft combined with dislocation of the ipsilateral hip.

Incidence

The first reported case of hip dislocation and femoral shaft fracture was in 1823, by Sir Astley Cooper.¹ Sporadic reports appeared in literature during the nineteenth century. Although several articles reporting multiple cases (including one bilateral injury)³ have appeared, the combination remains an exceedingly rare syndrome.

Wiltberger⁶ reviewed four cases at Henry Ford Hospital, occurring in 479,000 admissions, which gave an incidence of one for every 125,000 admissions. This contrasts considerably with the accepted fact that traumatic dislocation of the hip consists

of two to five percent of all dislocations.

Diagnosis

The lack of early diagnosis of this combination injury is quite striking in a review of the literature. Seventeen of the first 42 cases were not recognized as having dislocated hips until late; frequently the discovery was made several months later. Additionally, in ten of these 42 cases, no information is available to determine the time of diagnosis.

Although one-third of all reported cases occurred prior to the advent of x-ray diagnostic procedures, curiously, a better rate (50%) of early diagnosis was made in those cases, compared to the rate (40%) since the discovery of the Roentgen ray.

Early diagnosis of this combination injury gives a rather favorable prognosis, and awareness of this trauma syndrome should improve the percentage of early recognition. Dehne² suggests that a persistent adduction posture of the proximal femoral fragment should arouse suspicion of a concomitant hip dislocation.

The most certain method of early recognition of this and other combination injuries is an insistence on obtaining pelvis x-rays on all cases of femoral shaft fractures.

Mechanism of Injury

An adequate explanation of the

exact mechanism producing this dual entity has not been made, but it seems reasonable that there are two separate injuries involved. The initial event probably dislocates the hip, and is followed by a second force which fractures the femur.

Treatment

Because of the severe nature of the trauma necessary to produce this entity, there may be other complicating injuries which preclude early and optimal treatment. At best, this combination injury is difficult to treat. In particular, reduction of the hip by closed means can be impossible, because disruption of the femoral shaft leaves no means of controlling the proximal fragment.

The earliest cases reported in the nineteenth century were treated by allowing the femoral shaft fracture to progress with early healing for four to six weeks until enough stability was present to allow a manipulation and reduction of the dislocated hip. Although modern authors are not in complete agreement concerning treatment, waiting for this union before reducing the hip no longer seems acceptable.

Some authors advocate treatment of the hip first,⁴ even if this requires open reduction. Another⁵ recommends stabilization of the femoral fracture before proceeding with reduction of the hip. The bilateral

case was treated by reducing the hips with skeletal pin traction through the greater trochanters and later inserting Kuntscher rods in each femur.

In reviewing the literature, only two cases were found in which the hip was reduced early by purely closed methods.

Case Report

A 25-year-old white male was brought to the emergency room of Reid Memorial Hospital, Richmond, Indiana, following a motorcycle accident. Injuries consisted of a fracture of the left femoral shaft and a dislocation of the left hip (Figure 1A and B). Additionally, a fracture of the left tibia and fibula was noted.

Three hours after admission, the patient was taken to surgery. Two Steinmann pins were placed in the proximal tibia fragment and one in the distal tibia. These were incorporated in a short leg plaster cast. Preparations had been made to insert an intramedullary nail in the femur if the closed reduction was unsuccessful. Closed reduction, however, was accomplished by using vigorous traction on the femur, with the hip and knee each flexed to 90 degrees, and applying direct manual pressure to the greater trochanter.

The left leg was suspended in balanced Russell traction following the procedure. On the 20th day of hospitalization stay, an intramedullary nail was inserted into the left femur. The Steinmann pins were removed at surgery, and a long leg cast applied.

On the 38th day of hospital stay, the patient sustained a pulmonary

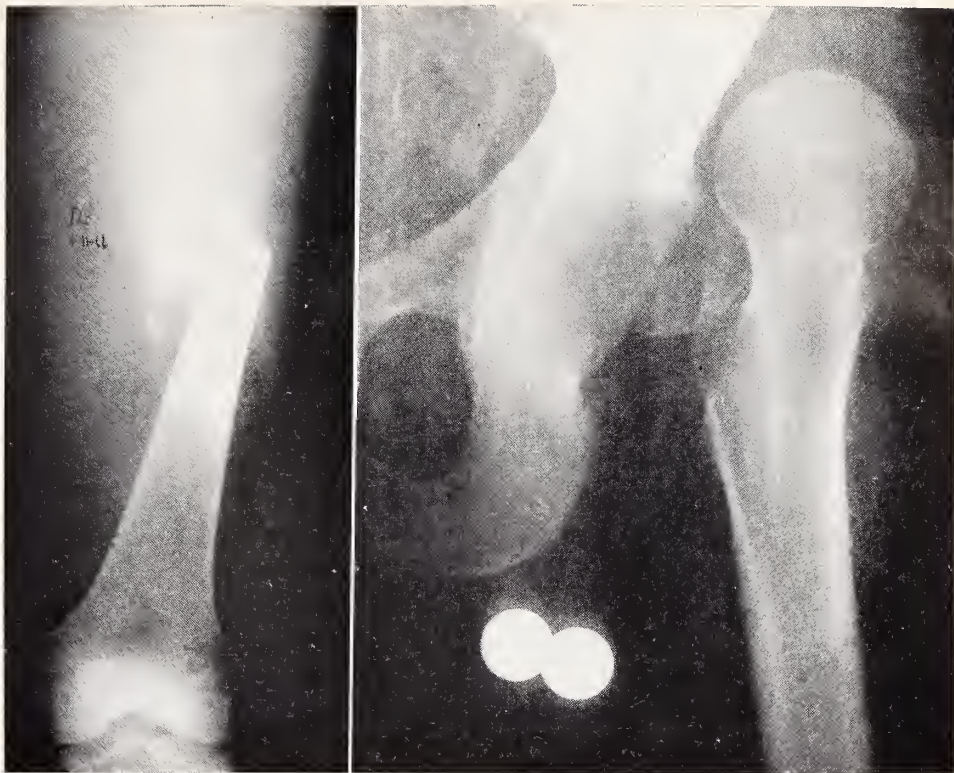


FIGURE 1

X-RAYS revealed a fracture of the left femoral shaft (1A) and a dislocation of the left hip (1B).

embolus. Anticoagulants were given during the remaining 21 days of hospitalization.

Twelve months after his injury, the patient had returned to work with no walking aids. All fractures had united and there was no sign at that time that avascular necrosis of the femoral head was present.

Summary

While dislocation of the hip and simultaneous fracture of the femur is a rare entity, this case points out that dual injuries in this area do occur and are frequently overlooked. Obtaining a hip x-ray on each and every case of femoral shaft fracture should insure that this and other trauma syndromes in the area do not go undiscovered.

REFERENCES

1. Cooper, Sir Astley: *A Treatise on Dislocations and Fractures of the Joints*, pp. 62-63, London, 1823.

2. Dehne, E., Immermann, E. W.: Dislocation of the Hip Combined with Fracture of the Shaft of the Femur on the Same Side, *J. Bone and Joint Surg.* 33-A:731, 1951.

3. Ingram, A. J., Turner, T. C.: Bilateral Traumatic Posterior Dislocation of the Hip Complicated by Bilateral Fracture of the Femoral Shaft, *J. Bone and Joint Surg.* 36-A:1249, 1954.

4. Key, J. A., Conwell, H. E.: *Management of Fractures, Dislocations and Sprains*, 7th Edition, p. 767, St. Louis, C. V. Mosby Co., 1961.

5. Watson-Jones, Sir R.: *Fractures and Joint Injuries*, 4th Edition, p. 678, Edinburgh and London, E. & S. Livingstone, Ltd., 1955.

6. Wiltberger, B. R., Mitchell, C. L., Hedrick, D. W.: Fracture of the Femoral Shaft Complicated by Hip Dislocation, *J. Bone and Joint Surg.* 30-A: 225, 1948.

1250 Chester Blvd.
Richmond 47374

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Romsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46208.

Associate Editors: A. W. Covins, M.D., 221 South Sixth
Street, Terre Haute; Loll G. Montgomery, M.D.,
Boll Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:

Term Expires

Harold D. Lynch, M.D., Evansville	Dec. 31, 1967
Jene R. Bennett, M.D., South Bend	Dec. 31, 1967
Alvin J. Holey, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gary	Dec. 31, 1968
Jock W. Hickmon, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969

Assistant Editor: Jackie Freers Stahl
Business Manager: James A. Woggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Drugs — Judgment or Regulation?

AS with many important issues today the subject of so-called "generic dispensing" is clouded with a great number of confusing and conflicting statements.

Generic prescribing is not new and has been an integral part of prescribing for many, many years. A drug usually has three names: a chemical name, which has significance primarily to the chemist and other scientists; a generic or public name, which is somewhat simpler and has greater understanding in pharmacology, medicine, and pharmacy; and a trade or brand name which conveys information as to the manufacturer of a particular product. Thus for particular generic drug entities there may exist different brand names, connoting a difference in the method of manufacture, controls at different levels of production, and a history of clinical performance characteristic of *that particular brand*.

A pharmaceutical product is more than a drug, and the care, skill and integrity employed in its manufacture may make all the difference in the performance of that product in a patient. There are those who would have us believe that all products con-

taining the same generic drug are therapeutically identical but this is not true. The Commissioner of the Food and Drug Administration in recent testimony and speeches has clearly indicated that although he might like to give the assurance that all drug products are clinically equivalent, at this point in time he cannot honestly do so.

A great deal has been made of the fact that the government buys drugs under generic names only. However, if one examines the bid awards, one finds that an overwhelming majority of products are supplied by brand name manufacturers. In a recent speech, a representative of the Defense Personnel Support Center indicated, "Basically, our problem is this: chemically equivalent items are not necessarily stable, therapeutically equivalent products . . . 45% of the pre-award samples submitted by the low bidder last year failed to pass our tests."

The truth of the matter is that the technology of understanding drug action, availability, absorption, excretion, binding, partition coefficient, solubility, enzymatic interaction and a host of other factors is still in its infancy. These are more than mere technical characteristics; they are determinants of therapeutic perform-

ance. Thus the history of *experience* by the physician and pharmacist and the integrity of the producer to produce drugs which result in consistently reproducible action is the most reliable guide available at this time. Any effort to remove the prescription decision from the physician and substitute some government constituted authority, is a dangerous proposal which could be detrimental to the health of the patient and a serious blow to high quality medical care in this country.

The number of products for which generic prescribing might result in savings for the patients represent less than 20% of the total number of prescriptions dispensed annually. In some of these instances the real savings are relatively insignificant. The proposed savings that are supposedly available have been wholly exaggerated. In the majority of instances of generic prescriptions, it has been the policy of most pharmacists to dispense only those products which experience has shown to be therapeutically reliable—generally a branded product.

The physician, who has the ultimate responsibility for the treatment of the patient, should be constantly aware of the drug products *prescribed* and *dispensed* for his patients.

He can on occasion, by consulting with his pharmacist, select products in which a degree of confidence can be assured with some cost savings resulting. However, an understanding of all parameters involved is essential. There have been too many instances where patients on maintenance therapy with such drugs as anticoagulants are hospitalized and products of different manufacturers are supplied with disturbing and even life-threatening results.

Regardless of the advancement of our scientific information, a great deal of the practice of medicine and of pharmacy involves the use of professional judgment. Any artificial barriers which interfere with the exercise of this judgment are unwise and dangerous. The physician should be free to prescribe the products which he deems best for his patients. Any changes in the medication should only come about after proper consultation between physician and pharmacist and only effectuated with the consent of the physician. Those who seek other approaches should make certain that they are fully aware of the consequences that may result and determine whether the risks involved are truly worth the savings. In the best interests of public health, we do not believe that they are!

Bills, now being considered by Congress, would, if passed, make it mandatory to prescribe generic drugs only for all patients under Medicare. Letters favoring preservation of the time-honored freedom and duty of a physician to prescribe for his patient the best available pharmaceutical preparation, whether generic or brand-name, should be written to your senators and representative.

Guest Editorials

The Killer

LAST year the United States had the dubious honor of setting a new record for accidents and fatalities.

Over 12 million persons were injured; by auto, inadvertent poisonings, industry, agriculture and such. Of these, 112,000 were fatal. This is 5,000 more than in the previous year and 20,000 more than in 1961—a 13% increase. Cloying as statistics may be, yet they serve to point out that four-fifths of the fatalities were due to motor vehicle accidents. The enormity of this is also apparent when one learns that the auto in the past 60 odd years has killed more people here in the United States than all our wars since the founding of our republic nearly 200 years ago. This is an epidemic, indeed!

In the panorama of road-crashes a triptych presents itself; namely, the auto, the road, and the driver, and it is the latter that is at the bottom of 85% of all car wrecks, literally and figuratively, especially when the seat belt wasn't fastened. Furthermore, the old theory is no longer tenable that accidents occur mostly in that relatively select group of "accident-prone" individuals. In short, anyone is eligible for membership in the lodge. The human factor looms as the most notorious, running the gamut from simple carelessness, ineptitude (physical and/or mental), to drug-induced tranquility, adventurously or no. The responsible physician always informs his patients, when prescribing certain medications, of their driving limitations. As for the auto; though it is readily admitted that a majority of accidents occur within 25 miles of home and at speeds of 40 miles per hour, or less, yet auto manufacturers vie with each other to woo the idolators of speed and puissance. If a 60 H.P. engine is sufficient for small plane, who needs 200+ H.P. in an auto? As for the road; one-way traffic routes, four-lane, controlled highways, chap-eroned by you know who, helps in reducing the toll.

Unless this carnage of the road is checked by driver-training, safer automobiles, safer roads, and education.

we'll need the population explosion just to keep our census stable. —
Franklin F. Premuda, M. D., Co-Editor, *The Lake County Medical News*, Vol. XXVIII, No. 3, March, 1967. Reprinted with permission.

Publisher's Memo

FROM time to time, and with increasing frequency, we get weary of listening to all the flap which relates, however remotely, to pharmaceutical prices. We hear that Company A sells a particular tablet for eight cents apiece but that Company B charges only three cents for its version of the same product.

In the first place, and let there be no mistake about this, most of the people who make noises about "generic equivalents" don't know an aspirin tablet from a jelly bean. They will shout that frozen tutti frutti pies "aren't as good as mother used to make"—and then turn right around and claim that generic and trade name products are like two peas in a pod.

You can buy a cow for \$25—or \$250. A local jeweler tells us that we can buy a 1-carat diamond for \$300—or \$2,300. In other words, we are always required to make decisions based on the quality of the merchandise and this axiom applies to anyone who wants to buy anything.

We are also a bit amused by acquaintances who will go out of their way to consult a high-priced specialist—and then complain when he gives them a prescription that costs \$3.50. (The average retail prescription price is \$3.48—on which the manufacturer nets 18 cents.)

We've made these same statements, perhaps more diplomatically, in earlier "Publisher's Memos." We may be compelled to repeat them again—perhaps even less diplomatically. Our parting plea is this: When you run across what seems to be an outra-

geous fact concerning prescription drug prices, consider the source, consider that the statement may have been made with ulterior motives—and remember that a bargain-basement price almost always bespeaks bargain-basement quality. — **Mac F. Cahal, Publisher, GP, Volume XXXVI, No. 2, August, 1967.** Reprinted with permission.

Young Driver's Record Worse

THE record of young drivers worsened in 1966, according to The Travelers Insurance Companies. Drivers under 25 were involved in almost 32% of the fatal accidents compared with 30.3% in 1965.

This commentary is contained in The Travelers annual highway safety booklet, which reports 52,500 deaths and more than 4,400,000 injuries on America's highways last year. Statistics in the booklet were compiled from reports by state motor vehicle departments.

The Bureau of Public Roads has reported that drivers under 25 constitute about 19% of all licensed drivers—but in 1966 they were involved in almost 70% more accidents than their numbers warrant. Older drivers, those 65 and over, showed a slight improvement in their driving records as did the largest group of licensed drivers — those 25 to 64. However, drivers over 65 continue to be involved in proportionately more fatal accidents than non-fatal accidents.

"Perhaps," says a Travelers spokesman, "it can be accounted for by saying that the young are quick and impatient and the old are stubborn."

The National Traffic Safety Agency has issued some vehicle safety standards. Some of the new features are included in or can be added to present cars. All of them are an important part of the nation's intensified efforts to reduce the traffic accident toll.

Research is also essential. At a Traffic Safety Conference in Hart-

ford, Conn. early this year there was wide agreement between auto insurance industry leaders and traffic safety research scientists that we need to learn more about how the various elements in the auto transportation system—the road, car, driver, laws, etc.—contribute to accident prevention.

Travelers already has invested more than \$250,000 in this type research and expects to contribute thousands more as research continues.

Parents of newly-licensed drivers should insist that the youngster should be driving a car that's mechanically sound. He should be solo-driving, or driving with his parents, not with a car full of chums. He should be driving on little traveled roads. And, he should be driving in daylight, only in fair weather at first.

Gradually, as handling a car begins to feel natural to him, he should—under supervision—begin driving under a variety of situations until all concerned have confidence that the young driver knows what he is doing, and why he is doing it. — **Suggested editorial, courtesy The Travelers Insurance Companies.**

Historical Notes...

Milk sickness, a common illness in Indiana during the summers of the 1800's, killed many persons, including Nancy Hanks Lincoln. This sickness was so common in Lawrence County that Dr. Joseph Gardner began to search for the micro-organism which could produce such an illness.

Born September 15, 1833, in Clark County, Indiana, Dr. Gardner was the son of Dr. George Gardner and Asnath Randal. Both parents died by the time Joseph was 14. He became an apprentice painter in order to make a living, but the reputation of his father lived on in the hearts of the people in the community. This force was so pressing that Joseph began to "ride" with one of the local

doctors and went into practice on his own at the age of 23.

His office was just across the river from Louisville University and so he began taking classes at the School of Medicine there and was graduated in 1861. Soon after the war began in 1862, he was appointed surgeon of Mariend Hospital. Later in his army career, he participated in the battle of Atlanta and was wounded by a Minie ball. The wound he incurred bothered him the rest of his life.

As a result of this wound, he was asked by the provost marshal to examine drafted and enlisted recruits of the fifth district, replacing Dr. T. S. Bell. He continued in this capacity until June 15, 1865, when he was discharged. In early 1866, he began his practice in Bedford, Indiana and this lasted until 1880.

He had become interested in a new instrument while he was in school at Louisville, and soon after he began his practice in Bedford, he bought one of the first microscopes to be brought to the United States. He began to study germs at home, and joined the newly organized "American Society of Microscopists." Microscopy became a great interest, and in 1887, he presented a paper before the society and it was published in the archives of that year.

In his paper, Dr. Gardner proposed that a filaria was the cause of milk sickness, as the disease only appeared during the dry summer months. He found a filaria on the foliage of the fields where the cows grazed, then in the blood stream of the cows which grazed there and also in the blood of those afflicted with milk sickness. So the cause for milk sickness was the filaria that was in the dew of the fields.

I told this interesting story to my friend, Dr. T. B. Rice, who drew from his prodigious memory the following story: "About 1920, a well trained young doctor began his practice in one of the smaller communities around Indianapolis and soon thereafter, there was an epidemic of

fever in his community. He began to examine the fresh blood of these patients under the microscope and lo, there were filaria. He knew nothing of the diseases caused by filaria and so he took the problem to his bacteriology professor, Dr. Frank Forry. The findings were so unusual that even Dr. Forry could not associate it with any of the diseases he knew.

"Dr. Forry searched the literature but there was no reference to any disease that was similar. Then he remembered some medical articles he had been reading previously in French, just to refresh himself on that language. He recalled an article on filarial-like masses of protein seen in the blood under certain conditions. So they did not have a new disease, after all.

"I was surprised and somewhat confused, and Dr. Rice noticed this. 'You know what caused milk sickness, don't you?' Dr. Rice asked, and then answered his own question, 'It was caused by the cows eating the roots of plants during the dry season when the grasses were dead. These roots were not poisonous to the cows but they caused the milk to be poison to people who drank it.'"

Dr. Gardner was a friend of Miss Clara Barton and as she was organizing the American Red Cross, she named him as the first president. He lived in what is now the city office building at Bedford and his farm was the center of a community south of Bedford known as Red Cross.—**R. B. Smallwood, M.D., St. Petersburg, Florida.**

Editorial Notes . . .

Polio gets scarcer each year. Only 15 cases have been reported in the U. S. in the first seven months of 1967. This is the lowest national total on record. It involves only ten states. Indiana has reported none. An epidemic in Nicaragua this summer, 600 cases and 78 deaths, which was controlled by massive immuniza-

tion programs with U. S. aid, serves as a reminder of the problem before immunization was possible. In 1955, the U. S. reported 28,985 cases.

The London Daily Mail reports that a new 300,000 pound maternity hospital in Somerset, England, will be obliged to operate with only half of its beds open because of a serious shortage of midwives. The superintendent is reported as doing and having done everything possible to staff the hospital, including her suggestion that the local council establish a nursery to care for the children of retired nurses who thereby could serve as midwives, and the operation of a special midwifery training school for nurses. If the situation gets worse, the hospital will close. One characteristic of socialism is that it discourages people from entering any type of life-work which renders a service to humanity; it is a selfish social order. England will never have enough nurses. It has not had enough doctors for many years; it will never have enough.

Parke, Davis and Company, in testimony before the Senate Finance Committee, has offered to present before the committee proof that certain generic products offered for sale as comparable to principal products made by Parke Davis are in fact not equal in quality nor in their anticipated effect. The offer was made during testimony in objection to bills which would establish a "Formulary of the United States" and establish prices for the drugs listed therein.

Five new medical schools opened this fall. The University of Arizona, Brown University, the University of Hawaii, Michigan State University and Pennsylvania State's Hershey Medical Center all have small opening classes in session now.

With some increases in admissions in other schools there is an increase of freshman students of 316—from 8,964 in 1966 to 9,280 this year. However, even with eleven more schools in the planning stages, medical education may not produce enough physicians.

The "thousands of deaths" predicted by a health physicist as a result of diagnostic x-rays have been characterized as guesswork assisted by sloppy statistical maneuvers involving hazy data. Dr. Joseph D. Calhoun of the American College of Radiology has issued a bulletin to calm the many Americans who were alarmed by the physicist's testimony as reported in the papers. Dr. Calhoun emphasizes that, as all practicing medical doctors know, there is no evidence that radiation at low levels has caused any injury to humans.

The London Daily Mail recently had words to say about medical education in England. The case in point was a scholastically well qualified girl who failed entrance to British medical schools for four years and then entered a school in Czechoslovakia. When and if she graduates with a foreign degree, she will be required to study an additional three years in Britain before entering practice. *The Daily Mail* says the situation is deplorable since practicing doctors are in short supply, but this is a crazy business and is caused by a shortage of medical schools. *The Daily Mail* also says it can suggest one source of money to build a new medical school—the 50 million pounds spent by the government for free prescriptions, most of them to those who can afford to pay. Someone in the U.S. should start a campaign to build more medical schools with the money the government spends to provide medical care to those who can afford to pay for it. ◀



G. O. LARSON, M.D.

President

Indiana State Medical Association

1967-68

Dr. G. O. Larson, LaPorte general practitioner, succeeded to the presidency of the Indiana State Medical Association during the annual convention in Indianapolis last month.

Dr. Larson received the gavel, emblematic of the office, from Dr. Eugene S. Rifner after an extremely busy year for both of them as president-elect and president of the association.

Dr. Larson was born in Waupaca, Wisconsin, in 1904. He obtained his pre-medical education at the University of Denver, his B.S. and M.D. degrees from Northwestern University and has practiced medicine in LaPorte since he finished his internship at Harper Hospital in Detroit in 1928.

Dr. Larson has been increasingly active in medical societies and in civic affairs. He has served as president of the following organizations: the LaPorte County Medical Society; the 13th District Medical Society; the LaPorte School Board (17 years); the Indiana State School Boards Association; the LaPorte Library Board and the LaPorte County Library Board; the LaPorte Kiwanis Club and the staff of Holy Family and Community Hospitals.

He served as alternate councilor (six years) of the 13th District Medical Society and as councilor for three years. He has served the ISMA as a member and chairman of numerous permanent committees and commissions and as a member and chairman of many of the reference committees of the association.

Other association activities include serving as a delegate from LaPorte County Medical Society for many years and as a member of the Executive Committee for the past three years. Dr. Larson also served on the board of directors of Indiana Blue Shield for 11 years.

His list of chairmanships and memberships on various civic organizations in LaPorte is exhaustive and includes church and school groups, the Boy Scouts, the Y.M.C.A., United Fund and the Chamber of Commerce.

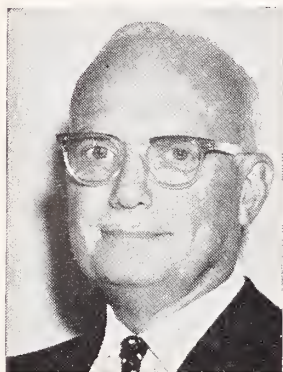
Dr. Larson and his wife, Gladys, have two children — a daughter, Margery and a son, Bob, and three grandchildren.

Dr. Larson's civic activities in LaPorte include the First Methodist Church, Chamber of Commerce, the LaPorte Kiwanis Club, Lambda Chi Alpha fraternity and Phi Rho Sigma, Alpha chapter.

He brings to the ISMA presidency over 30 years of experience in serving — his patients, his community, his church and organized medicine.

President's Page

May I speak for all of your officers when I extend greetings to members of the best and most dedicated state medical association in America. This is my personal opinion, but you are the ones who have proven it to be correct. I do appreciate your confidence, and I accept the honor of serving as your president with confessed humility. I recognize the challenge of accepting the gavel from one who has given us such devoted leadership as has Dr. Rifner.



Long ago I learned the virtue of brevity. So if you will pardon the "medical irony," what I have to say will be in "capsule" form. I think it would be inappropriate and repetitious to refer at this time to any details concerning the difficult problems which we have faced in the past few years. You know them all too well. You know, too, that there are many more still ahead for us. I have come to have increasing respect for the philosopher who said: "The trouble with our contemporary society is that we have our scientific foot in the airplane and our social foot in the ox-cart." Let's remember that the word "social" involves a bit of politics. The evidence is all too clear that our medical science has done pretty well. I prefer not to mention that "foot in the ox-cart."

The one thing that I wish to emphasize today is our association's need for better communication. The most effective vehicle to provide that service is our own medical *Journal*. Will you please assure me that you will read each issue as an in-service professional responsibility? And please don't forget that there is a "President's Page." This will be my number one way of communicating with the membership. I will try my best to make it meaningful and a means of reflecting the continuity of our program as well as the most urgent areas to be emphasized at a particular time. I may even invent some "gimmicks" to increase reading loyalty not only for the President's Page, but for our excellent *Journal* as a whole.

I am aware that I will need some kind of magic formula to find the time to make all of the meetings and speaking assignments that are an automatic part of this office. I know, also, that all too often I will be introduced with extravagant adjectives which I don't deserve. But I have the answer to that one. I will merely mention the Kentucky hillbilly who, after asking for a drink, was handed a glass of cold water. The story has it that he took a mouthful, gargled it, spat it out, and said: "Mister, you know there are folks who would swallow that stuff."

Our profession is so completely serious, I thought you might permit me to conclude with a bit of levity. I think you might enjoy this clipping recently handed to me by a friend:

Methuselah ate what he found on his plate
And never, as people do now
Did he note the amount of the caloric count:
He ate it because it was chow.
He wasn't disturbed as at dinner he sat
Destroying a roast or a pie
To think it was lacking in granular fat,
Or a couple of vitamins shy.
He cheerfully chewed every species of food,
Untroubled by worries or fears,
Lest his health might be hurt by some fancy dessert,
And he lived over 900 years.

Again, I speak for all of your officers when I say *thank you* for the honor of serving you in the year ahead, and for your full cooperation which I am sure we can anticipate.

G. O. Larson M.D.

Night Leg Cramps ... Unwelcome Bedfellow In Diabetes¹, Arthritis², and Peripheral Vascular Disorders²

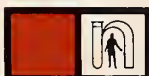


now ... specific therapy for night leg cramps

Walker

QUINAMMTM

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.³ Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.



THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

Prescribing Information: Composition: Each white, beveled, compressed tablet contains: Quinine Sulfate 260 mg. and Aminaphylline 195 mg. **Contraindication:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions:** Aminaphylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets. **References:** 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuk, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

6/67 Q-706A



at the site of infection
(where it counts)...

Ilosone® provides more antibacterial activity than any other oral erythromycin

Acid stable, better absorbed ... Ilosone produces faster, higher, more prolonged blood levels, even in the presence of food^{1,3}

Because it is the most active form of oral erythromycin, Ilosone can help assure consistently greater antibacterial activity at the site of infection. Ilosone produces peak antibacterial blood levels two to four times those of other erythromycin preparations.^{1,2} Not only are these levels attained earlier, but they are maintained for much longer periods. Even the presence of food does not seem to affect the activity of Ilosone.^{1,3}

In the treatment of patients with bacterial infections susceptible to erythromycin, Ilosone has compiled an excellent therapeutic record. Since it exerts its greatest activity against gram-positive organisms, it is particularly useful in common respiratory and soft-tissue bacterial infections. Ilosone kills—not merely inhibits—streptococci, pneumococci, and more strains of staphylococci than any other macrolide antibiotic. This bactericidal action, coupled with the high antibacterial levels

attained, makes Ilosone especially valuable in patients with low host resistance, such as infants, debilitated individuals, and diabetics.

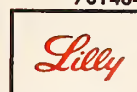
Ilosone has shown no cross-resistance with penicillin and may be effective against organisms that have become resistant to that agent. Despite its high antibacterial activity, Ilosone has demonstrated a low incidence of side reactions. Blood dyscrasias, ototoxicity, and tooth staining have not been observed. Infrequent cases of drug idiosyncrasy, manifested by a cholestatic jaundice, have occurred, but there have been no known definite residual effects.

Now available:

New! Ready-mixed Ilosone Liquid 125!
(Contains erythromycin estolate equivalent to 125 mg. erythromycin base per 5-cc. teaspoonful.)

Ilosone®
Erythromycin Estolate

701464



(See next page for prescribing information.)

Ilosone®/the most active oral form of erythromycin

Description: Ilosone is the most active form of oral erythromycin that has been developed. Because it is stable in acid, well absorbed, and excreted in lesser amounts in the bile, it provides faster, higher, and longer-lasting levels of antibacterial activity (ABA) in the serum, even when taken with food, than do comparable doses of erythromycin.

Indications: Ilosone is indicated in infections caused by micro-organisms sensitive to its action—especially staphylococci, hemolytic streptococci, and pneumococci.

It has been effective in streptococcus infections, particularly acute bacterial pharyngitis and tonsillitis; staphylococcus disease, including soft-tissue infections, furunculosis, abscesses, cellulitis, carbuncles, and wound infections; pneumococcus pneumonia and acute bronchitis with pneumococci on culture, bronchopneumonia, and otitis media.

In serious staphylococcus infections, erythromycin preparations should be used only in combination therapy with other antimicrobial agents; surgical procedures should be performed when indicated, and large doses of the antimicrobial agents should be employed.

Penicillin is the drug of choice for syphilis and gonorrhea, but Ilosone in multiple 500-mg. doses has been useful in patients with a history of penicillin allergy. Also, other infections due to susceptible bacteria in patients hypersensitive to penicillin or other antibiotics may be considered for treatment with Ilosone.

Contraindications: Known history of sensitivity to this drug; preexisting liver disease or dysfunction.

Adverse Reactions: Hepatic dysfunction with or without clinical jaundice has been reported infrequently. Changes in liver function tests indicative of intrahepatic cholestasis appear to be the result of individual idiosyncrasy. Findings subsided when treatment was discontinued. Occasionally, symptoms simulated extrahepatic obstructive jaundice or the colic of biliary tract disease.

When jaundice appeared to be related to use of the drug, laboratory findings were characterized by increased direct-reacting bilirubin, elevated alkaline phosphatase levels, negative or weakly positive cephalin flocculation and thymol turbidity tests, elevated serum glutamic oxala-

cetic transaminase levels, peripheral eosinophilia, and normal cholecystograms.

Gastro-intestinal disturbances not associated with hepatic effects and occasional allergic manifestations (urticaria, skin eruptions, and, rarely, anaphylaxis) have been reported. The normal intestinal gram-negative bacterial flora is not appreciably altered by erythromycin drugs.

Administration and Dosage: Ilosone is administered orally.

Infants and children under twenty-five pounds, 5 mg. per pound every six hours; twenty-five to fifty pounds, 125 mg. every six hours. Adults and children over fifty pounds, 250 mg. every six hours.

For severe infections, double the dosage. When larger doses are indicated, consider parenteral erythromycin therapy. In beta-hemolytic streptococcus infections, maintain treatment for ten days to prevent rheumatic fever or glomerulonephritis.

In syphilis, a total of 20 to 30 Gm. is administered in divided doses for ten to fifteen days. Close follow-up is necessary since erythromycin drugs have not had adequate evaluation in all stages of syphilis. Examination of spinal fluid is recommended during follow-up.

In gonorrhea, the dosage is 500 mg. four times a day for four days. Patients with a suspected lesion of syphilis should have a dark-field examination before receiving antibiotics and monthly serologic tests for three months. For detailed information, consult the package literature.

How Supplied: Pulvules® Ilosone, Capsules, N.F., 125 mg.* and 250 mg.*

Ilosone Liquid 125, Oral Suspension, U.S.P., 125 mg.* per 5-cc. teaspoonful.

Ilosone, 125, for Oral Suspension, N.F., 125 mg.* per 5-cc. teaspoonful.

Ilosone Drops, 5 mg.* per drop.

Tablets Ilosone Chewable, N.F., 125 mg.*

*Base equivalent.

[080967]

References: 1. Griffith, R. S., and Black, H. R.: *Am. J. M. Sc.*, 247:69, 1964. 2. Griffith, R. S., and Black, H. R.: *Antibiotics & Chemother.*, 12:398, 1962. 3. Hirsch, H. A., Pyles, C. V., and Finland, M.: *Am. J. M. Sc.*, 239:198, 1960.

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.



The Woman's Auxiliary

REPORTS TO ISMA

This is undoubtedly the busiest time of the year for all Indiana State Auxiliary presidents. September was a month of great activity with many highlights. It began when I attended the IMPAC meeting which was held in Indianapolis Sunday, September 10th. The program was excellent. Many of the speakers were from other states and the session concluded with an address by Dr. Edward

Annis of the Florida Medical Association. September 19th I had the pleasure of attending the Allen County Auxiliary Membership Tea which was held at the home of Mrs. Robert Flaherty. Mrs. Gerald Nolan serves as president of the Allen County Auxiliary.



September 20th, our Indiana State Auxiliary workshop was held in Indianapolis. This meeting was planned for all county officers and chairmen. I am very pleased to report that we had 24 auxiliaries represented. The ladies came bright and early (9:30) from such distant points in the state as Floyd, Vanderburgh Southwestern, Vigo, Elkhart, Lake, LaPorte, Allen, Randolph and Wayne-Union counties. The state chairmen gave excellent presentations to the 69 ladies who attended. The film "Dance Little Children" (an adult film on V.D.) was shown and most of the ladies who attended voluntarily expressed their appreciation for the showing of the film.

September 27th and 28th, Mrs. Frank Gastineau and I attended the Kentucky State Auxiliary meetings in Louisville, while our president-elect represented the Indiana Medical Auxiliary in the state of Michigan.

This brings us to ISMA Convention time. We have been kept busy carrying out plans made during the summer. We hope your ladies enjoyed the luncheon and entertainment planned for them at the Columbia Club.

Roberta P. Deever

Meet The Journal Staff



Dr. Samuel Robertson Mercer served as a member of the Editorial Board of *The Journal* from 1954 to 1962 and in 1964 was selected as an Associate Editor. He practices his specialty of dermatology in Fort Wayne where he is a member of the medical staffs of Parkview and St. Joseph's Hospitals.

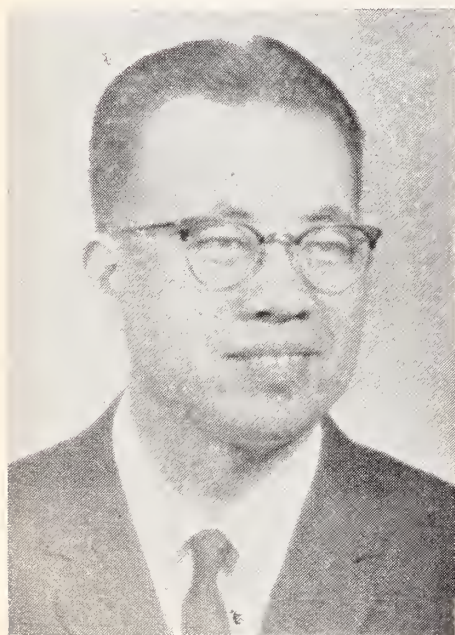
Dr. Mercer is a native of Pittsburgh. He attended public schools there, studied at the University of Syracuse and obtained his B.S. and M.D. degrees from the University of Pittsburgh. He served a rotating internship at St. Francis Hospital in Pittsburgh.

After engaging in general practice in Langloth, Pennsylvania, he spent two years in a Fellowship in Dermatology at the Mayo Clinic, and was resident physician at the New York Skin and Cancer Hospital for one year. Before entering practice in Fort Wayne, he was Acting Assistant Surgeon for the U.S.P.H.S. Hospital at Stapleton, New York, and served as Surgeon for the United States Lines.

Dr. Mercer is a Diplomate of the American Board of Dermatology, Fellow of the American College of Physicians, member of the Chicago Dermatological Society, the American Academy of Dermatology, and the

Fort Wayne Academy of Medicine and Surgery.

He is also director of the Fort Wayne City Clinic and was formerly instructor in dermatology in Parkview and St. Joseph's Hospitals. In addition to his practice and clinic work, he is active in clinical investigative work involving new pharmaceutical products.



Dr. Wei-Ping Loh has been a member of the Editorial Board of *The Journal* since 1965, and prior to being elected was, for several years, one of its most loyal contributors.

Dr. Loh was born in China and received his M.D. degree (with honors) from the National Medical College of Shanghai. After one year of rotating internship and one year of residency in internal medicine at his alma mater, he took postgraduate training in internal medicine at the Thomas D. Dee Memorial Hospital in Ogden, Utah, and the Bellevue Hospital in New York City.

Nine months at the University of Michigan earned him an M.P.H. degree, and three semesters at Boston University were rewarded by a Ph.D. degree in medical microbiology. He had additional training in pathology at Boston University.

In 1954 Dr. Loh was instructor in pathology at Indiana University School of Medicine and assistant pathologist at the Indianapolis General Hospital. In 1956 he became clinical pathologist and in 1961 chief pathologist for the Gary Methodist Hospital, where he has worked ever since.

He is associate professor of pathology at the Chicago Medical School, chief pathologist to the Lake County Coroner's Office and consulting pathologist for the Parramore Hospital of Crown Point and the Beatty Memorial Hospital at Westville.

Dr. Loh is a Fellow of the American College of Physicians, the American Society of Clinical Pathologists, the College of American Pathologists, the American Public Health Association and the American Association for the Advancement of Science. His special interests include clinical hematology, forensic pathology, medical writing and hematologic research. ◀

From a continuing study on nasal congestion . . .



timed to work while your patient does

A study being conducted by the Department of Otolaryngology, Greater Baltimore Medical Center is stockpiling evidence that points to the fast action and prolonged relief effected by Triaminic in the treatment of nasal congestion.

Begun in March 1966, the study to date has encompassed 85 patients with common nasal disorders—

and measured their response to recommended doses of Triaminic tablets.

Timed to release its oral nasal decongestant and two antihistamines within 8 hours, Triaminic was found to effect partial or complete relief in better than 82% of the subjects treated. Clearing nasal obstruction. Reducing turbinate swelling. Making breathing easier.

It's a comforting thing to know that Triaminic really works.

Triaminic[®] *timed-release tablets*

Each timed-release tablet contains:

Phenylpropanolamine hydrochloride 50mg. Pyrilamine maleate 25mg. Pheniramine maleate 25mg.

Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets.

Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES • *a division of The Wander Company* • **LINCOLN, NEBRASKA 68501**

Indiana School for the Blind

DIANE B. BRASHEAR, M.S.W.
Indianapolis*

MANY of you, driving through the northern residential section of Indianapolis, have had occasion to see signs, and even drive past the Indiana School for the Blind. From College Avenue it appears to be a large structure resembling many state institutions, and appears to some, I am sure, awesome and aloof.

Certainly, many professional people including myself have resisted these institutions, perhaps because of preconceived ideas. Mine stemmed from my graduate school days when I was placed to work in a state mental hospital with its dark halls, institutional smell and isolated atmosphere. I was prepared for a similar experience when I first visited the School for the Blind. I felt small in comparison to the high tower that can be seen from a far distance. I prepared my nose for the antiseptic odor, which I had long associated with old buildings and steeled myself for the depression I thought I might experience when I was forced to view children with a handicap which I personally find to be most difficult.

Instead, my reservations left me within a few moments because I almost was run over by a student running freely and securely down the hall. Laughter came from several areas. Groups of students were discussing something in an excited, happy tone and one was being soundly scolded by a teacher. Within a brief period of time my previous qualms were dispelled by evidence that this was not like other institutions I had known. Indeed, this was a school, and the atmosphere conducive to learning was evident through-

out the building. What better way for a five-year-old to experience learning than in a bright, colorful room providing a variety of stimuli, in a small classroom with individual attention of the teacher, an opportunity to hold a lovable and tolerant rabbit who shares classroom experiences? If one has to live away from home and go to school, what better way than in an attractive dormitory with houseparents who are interested, maybe even more so than others left behind at home?

A Total Living Experience

What then is the Indiana School for the Blind? It is a state-supported school committed to the education of children who are legally blind and cannot be served for various reasons in their own community. Why a residential school? There are some who feel that it is possible to educate a handicapped child through classes in public school and to work with the family concurrently. One only has to look through the school here to understand that the concept of education for the blind child is not limited to the classroom. With a team of personnel committed to the education of the child, one quickly realizes that learning for the blind child is a total living experience, not readily or easily taught in a school that keeps only regular school hours. Mobility, group experiences for social contact, riding a bike, experiencing frustration, bumps, discipline, and becoming independent are just as important as learning to read large print or braille.

Maintaining this educational approach are a group of people who are an example of the multi-discipline approach. This concept, long estab-

lished in the psychiatric field, lends itself to the program of the school. For example—when a family applies to the school to have their child considered as a student, the child is first tested by a psychologist, then seen by a child psychiatrist, along with the family being evaluated by a psychiatric social worker. This family may or may not have already been contacted by the school nurse, who often knows potential students from the time they are known to be blind.

The child visits the classroom and is observed in this situation. Sometimes neurological examinations are requested. After a complete evaluation is made, staff members, comprised of the school superintendent, school principal, psychologist, child psychiatrist, psychiatric social worker and the nurse, meet to determine whether the child's needs are best met by the school and how they can be met. Is it better to repeat kindergarten if he has not made progress? Are his parents having difficulty in accepting and handling his blindness? If they are, should they be seen by the social worker regularly for help? Is this child too retarded or too handicapped to attend regular school sessions, but should he participate in the summer program recently initiated by the school for the multi-handicapped? These questions and others like them are dealt with on a professional level.

And, as the child progresses in school, problems are also handled in a similar fashion. The staff has learned these children often require help for a considerable period of time before their entrance into a formal school program. The school staff feels that helping the parents and the child the day the blindness becomes apparent is the only way that offers maximum adjustment for the child. The emotional problems inherent in having a blind child and learning how to cope with these problems requires help on many levels.

* Chief social worker, Indiana School for the Blind.

The nurse helps with definite problems in handling the development of the child. The social worker can aid in helping the parents accept their child for what he, himself, has to offer. He may be blind, but certainly he has the capacity to love and be loved. He can do all the things other children can do and at the same time be a productive and worthwhile human being.

Accepting the Truth

Our reactions to blindness tend to present themselves in various ways. Some of us tend to deny that it is a lasting condition, and so we feel that we have to offer hope to the family that this condition may, in time, be cured. After all, we say, as in other problems, medical science has not learned everything and there may be a hope of overcoming this problem. This attitude, while it may help us to handle our anxiety and concern at the moment, usually offers false hope to the family and helps them to deny what they want to deny anyhow, that is—that Johnny

cannot see. Some parents learn to accept what they consider a burden, feeling that the child who is visually limited will always have to be cared for, fed, led. Helping these parents understand that this is not the answer at the initial diagnosis of the visual problem is the most helpful thing any family physician can do.

Next, putting a family in touch with the people who have knowledge of blindness and who have training and experience to cope with the problem is the next most important step. Our child psychiatrist, Dr. Nancy Roeske, who is also director of Riley Child Guidance Clinic, recalls a couple, who after learning that their child couldn't see, knew of no one to turn to and finally sought the help of the blind newsman on the street corner. Let us hope that we can be more readily available and meet with these people before they become desperate enough to seek unqualified help.

Each year the School for the Blind has a conference for parents of pre-

schoolers who are visually handicapped. These parents come to the school, participating in group sessions. It is my impression that the parents who receive help early in their child's visual problem are best prepared in helping their child to mature and develop within the capacities he has.

Each child, like all children, has certain talents, assets and levels of ability. Our job is to help them develop these abilities to the fullest. Your job is to let us have these families and children early enough to be of some real help. Not all children are candidates for our school, but all children who are visually handicapped can be helped by our knowledge and experience.

We welcome any family or physician who contacts us for help, regardless of whether they feel the child may become a student or not. Let the School for the Blind share its knowledge, enthusiasm and confidence that a visually handicapped child can grow into an independent, contributing citizen.

I.U. School of Medicine Postgraduate Courses (Division of Postgraduate Medical Education)

DATE	COURSE TITLE	LOCATION	COURSE DIRECTOR	A.A.G.P.* HOURS
Dec. 6	Clinical Aspects of Learning Disabilities	Stauffer Inn, Indianapolis	Paul R. Dyken, M.D.	5½
Dec. 13	Management of Hypertensive Cardiovascular Disease	Marion County General Hospital	Bill L. Martz, M.D.	8
Jan. 10	Common Problems in Cardiology	Marion County General Hospital	Charles Fisch, M.D.	8
Jan. 24	Office Endocrinology	I.U.M.C.	William P. Deiss, M.D.	8
Jan. 25	Emotional Problems in General Hospital Practice	Prtestant Deacaness Hospital, Evansville	H. Jerame Rietman, M.D.	4
Feb. 7	Anesthesiology far the General Practitioner	I.U.M.C.	Vergil C. Staelting, M.D.	8
Feb. 14	Emergency Care af the Trauma Patient	Marion Cauntly General Hospital	Paul Benedict, M.D.	8
Feb. 28	Management of Liver Disorders	I.U.M.C.	Philip Christiansen, M.D.	8
Mar. 20, 21, 22	Electracardiagraphy far Physicians	I.U.M.C.	W. Danald Close, M.D.	24
March 27	Practical Management af Pulmonary Diseases	I.U.M.C.	Ray Behnke, M.D.	8
April 24	Emotional Problems in Family Practice	Dunn Memarial Hospital, Bedford	Danald Kerr, M.D.	5
May 8	Orthopaedics far the General Practitioner	I.U.M.C.	James Wray, M.D.	8

* Prescribed hours credit by the American Academy of General Practice

News from Indiana University School of Medicine

APPPLICATION of new knowledge is a field with which medical schools have not been concerned until recently, but with the rising demand for generally available higher quality of medical service, medical education is changing rapidly, Dr. John B. Hickam, chairman of the Department of Medicine at the Indiana University School of Medicine, recently told the graduating seniors at the school's third annual Honors Day program at the Medical Center Union Building.

Dr. Hickam pointed out that with the tremendous explosion in knowledge, it now is impossible for all important knowledge to be known by one individual. "If it was, it would be obsolete in a few years anyway," he observed.

With increasing pressure for more "primary physicians" (successor to the old general practitioner), as opposed to specialists, it will become more important for the medical schools to find new methods of continuing education and closer and closer cooperation with practicing physicians, Dr. Hickam said.

"We at Indiana University know we have to get out and do something about the application of medical care," Dr. Hickam said, declaring that the faculty had devised the "Indiana Plan" for medical education in response to this need. This plan, now in an early stage of implementation, will spread both graduate and undergraduate medical education throughout the state, using faculty members located at hospitals in many different communities, and will make the latest information available to all Hoosier physicians by a telephone and closed circuit television network.

Twelve students shared in 10 out-

standing scholarship awards in the Honors Day observation. The top award, the Ravdin Medal given annually by Dr. Marcus Ravdin of Evansville to the senior student having the highest scholastic record, went to Alden Theodore Schmidt, Jr., son of Mr. and Mrs. Alden Schmidt, Highland, Ind. Mr. Schmidt had almost a straight "A" record for the four years.

Tied for second place in the class scholastically were Thomas E. Hayhurst, son of M. E. Hayhurst, Naperville, Ill., and Michael H. Thomas, son of Mr. and Mrs. John S. Thomas, Huntington, Ind. They shared, along with the first place winner, in the Mosby Scholarship Book Awards, the Merck Manual Awards and the Lange Medical Publications Award.

Third place in the class went to Michael Bruce DuBois, son of Dr. and Mrs. Ramon B. DuBois, Lafayette. He shared in the Mosby Scholarship Book Awards and the Merck Manual Award.

Miss Carolyn Ann Cunningham, daughter of Mr. and Mrs. Earl Cunningham, Route 1, Kingman, was fourth in the class. She shared in the Mosby Scholarship Book Awards and the American Medical Women's Association Award for women in the upper 10% of their class. The latter award also went to Mrs. Patricia Hughes Hartlage, Lawrence, daughter of Mrs. Joseph Hughes, 2002 East Kessler Boulevard, and Miss Patricia Amanda Andrews, daughter of Mr. and Mrs. Robert T. Andrews, Concord, N. H.

The scholarship awards were presented by Dr. Glenn W. Irwin Jr., medical school dean.

Dr. Barbara Stillwell, a member of the class of 1964, presented the

Dr. Mary Jean Yoder Memorial Award for her class to Roy Keith Huntman, son of Mr. and Mrs. John LeRoy Huntman, Route 7, Indianapolis. The award memorializes Dr. Yoder, a member of the class who was killed in an automobile accident near her home at Goshen immediately after her graduation, and is given to the student who most nearly approximates her academic achievement, high moral character and dedication to others in a Christian framework. The winner's name is engraved on a permanent plaque in the Union Building and he or she receives an individual plaque and \$30.

John Harry Isch, son of Mr. and Mrs. Harry A. Isch, Bluffton, won the Roy Rheinhart Memorial Award given in the Department of Obstetrics and Gynecology by the class of 1958. Mr. Rheinhart, a member of that class, was killed in an automobile crash his senior year along with his wife and their child. The award goes to a student considered outstanding in his clerkship in the department. It was presented by Dr. Carl Huber, department head.

A new award given by the Department of Psychiatry was presented to Sylvan Dean Eller, son of Mr. and Mrs. Ralph C. Eller, Route 4, Delphi, by Dr. John I. Nurnberger, department head. It included, Dr. Nurnberger said, "A travel allowance to bring him back to Indiana after his internship."

Donald Alva Parsons, 1511 Maxwell Lane, Bloomington, son of Mrs. B. Gail Parsons, Ada, Ohio, was one of 10 senior medical students in the United States to win the \$100 Sanford Award of the American Society of Clinical Pathology for meritorious original research in pathology. In

addition to the money he received a medal and certificate presented by Dr. Frank Vellios, head of the Department of Pathology.

The president of the senior class,

Ted Wood Grisell, son of Dr. and Mrs. Ted L. Grisell, 5211 Brendenridge Road, received the Dean's Award, a cash award of \$50 established by the School of Medicine

Executive Committee to be presented to the senior student who, from the viewpoint of the administration, has given the greatest service to his class. ◀

DAY BY DAY WITH THE FDA

From the FDA Reports on Enforcement and Compliance.

A mobile manufacturing plant for making hallucinogens has been confiscated. Colorado police located and seized a truck with a large supply of LSD, mescaline and DET, and all the equipment and chemicals for making more. The truck was an old milk-collection truck and was apprehended because of the suspicious nature of the two passengers and the fact that they did not stop at a port-of-entry station at the Utah border.

* * *

The Indiana State Board of Health provided information which led to the seizure of 548 cases of canned fruit-type drinks shipped into the state by a firm in Michigan. Labeling claimed a level of vitamin C which on analysis was found to be short by variations from 30% to 100%.

* * *

Shelled pecans and frozen shrimp, from Louisiana and Japan respectively, were seized in Los Angeles because of contamination with E.

coli. This is remindful of the bacteriologist's dictum that the entire surface of the world is covered by a thin layer of feces.

* * *

Seizure actions by the FDA include that of a quantity of Vita-Bio-Powr, identified as calcium polysulfide, and manufactured by the Prune and Fruit Powder Company of Los Angeles. The seizure was on the basis of false and misleading claims of "exerting a detoxifying action combined with a non-specific stimulation of the general defense mechanism of the body."

* * *

The Florida State Department of Agriculture utilizes a detection device called a "pestilizer" to measure pesticide residues on vegetables. Recently an entire field of celery was packaged for the market and upon testing was found to be unfit for use as food due to a dangerous amount of parathion residue.

* * *

A Denver, Colorado firm has been found to be manufacturing parenteral solutions without the necessary preliminary of filing a New Drug Application. Joint inspections by the Colorado Health Department and the FDA caused a cessation of the project.

* * *

Dr. Herman Taller, author of the best-selling book "Calories Don't Count" has been found guilty on 12 of 49 counts. He was fined \$7,000, given a suspended two-year prison sentence and was placed on probation for two years. He will appeal. Besides authorship of the book, Dr. Taller was implicated because of his connection with a company which sold capsules of safflower oil and vitamins which carried a label on the container claiming that the user could control body weight, reduce obesity and maintain slimness by taking the capsules and at the same time consume thousands of calories daily without regard to total caloric intake so long as the diet was high in fat. ◀

What's Ahead for Blue Shield?

(One of a series prepared by Blue Shield)

The real test for Indiana Blue Shield in the years ahead is how well we serve our members and the rest of the people of Indiana. The immediate future holds a serious challenge, both to Blue Shield and to medicine. Where we go depends upon our capacity to determine what is needed in the area of health care financing, and upon our ability to furnish the public what is needed and wanted. If we don't develop and sell the required benefits at a price most people can afford to pay, it is probable that the government will attempt to extend its health care programs to cover most, if not all, of the population. Our only solution to that problem is to continue with the development of new programs to meet the demands of all of those who are now protected by Blue Shield and by private insurance companies. We must continue to demonstrate to government and industry that we can do the job, and that there is no need for further government involvement in the health care field. The basic needs of the elderly and the medically indigent have been met.

Among the new programs that are being considered by Blue Shield Plans and the insurance industry you will find dental care, psychiatric care, home and office call coverage, preventive medicine and prescription drugs. Indiana Blue Shield is ahead of the game in some of these areas, and has done some planning and investigating in the others. We have developed and will continue to de-

velop new programs in anticipation of customer demand, so that industry can choose the one best suited to their needs from a variety of programs. Blue Shield and the medical profession want to play a strong role in selecting and developing these new programs, and in determining the manner in which such benefits will be provided.

A major problem is how we administer the new program for steel, which was effective August 1. Nationally one million steelworkers and their families are now covered by a new program of benefits which provides full reimbursement of reasonable charges for presently covered services, plus pre- and post-natal and in-hospital medical care. Recently Robert E. Rinehimer, vice president-sales, Pennsylvania Blue Shield, said: "The steel industry and union could care less whether we use prevailing fee, usual and customary, fair and reasonable, or other comparable terms. What they are primarily interested in is the efficient delivery of goods. We have just one year to demonstrate our ability to handle the job. Our performance will be measured against that of other carriers." This approach is not much different from that of the automobile industry, and the telephone industry.

Indiana Blue Shield introduced a prepayment plan for dental expenses in 1965. It was developed co-operatively with the Indiana State Dental Association, and is being offered on a pilot basis through employers with

100 or more employees. The program includes a basic plan with a choice of two options that can be added to strengthen the benefit program.

Our home and office call program was offered on a pilot basis as early as 1952.

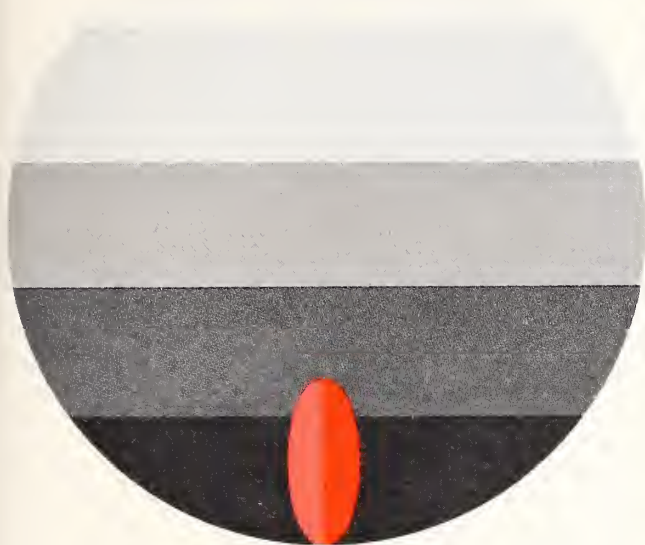
Some elements of psychiatric care are covered in most of our basic and major medical programs, but the development of a full psychiatric program is a task ahead. The same thing is true of preventive care.

Our first major medical program was offered in 1961, and had proved to be one of our strongest programs. Presently a major medical program is available to federal employees, doctors, lawyers and other major accounts. It is also available to our direct pay members, and the 65 and over who are protected by our Medicare supplement program.

Since organization in 1946 Indiana has stressed the development of new and broader benefit programs, and this will continue in the period just ahead. The physicians of Indiana can do much to help us select the programs to be offered, and the method used to furnish the benefits.

If the practice of medicine and the prepayment mechanism are to remain in the private sector of the economy, Blue Shield with the assistance of physicians, must complete the job we have started, and continue to develop more comprehensive benefit programs of the type desired by the public, offered at a cost the public can afford to pay. ◀

W. C. Huddlestone
Communications Division



“low man” in acne

By far the most significant development in the therapy of acne has been the use of broad-spectrum antibiotics for the control of infection — and in particular, the use of the tetracyclines.¹ After initial suppressive therapy, the maintenance dose is kept as low as possible. You can provide low-dosage therapy most conveniently with DECLOMYCIN, the long-acting, broad-spectrum antibiotic.

With DECLOMYCIN you can maintain high blood and tissue levels for extended periods on minimal dosage. And because of longer persistence time in the bloodstream, a missed dose need not impair effectiveness of therapy. Isn't DECLOMYCIN the logical broad-spectrum antibiotic for low-dosage therapy in acne?

1. Witten, V. H. and Helfman, R. J.: in Modell, W.: *Drugs of Choice 1966-1967*. C. V. Mosby Co., St. Louis, p. 732.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

For a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill.

“low man” in acne

DECLOMYCIN Demethylchlortetracycline should be equally or more effective than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York



DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Physicians and Hospital Not Liable for Misdiagnosis of Tubal Pregnancy—In a suit for damages against two physicians and a hospital for injuries resulting from their alleged negligence in misdiagnosing her tubal pregnancy as pelvic inflammatory disease, a verdict in favor of the physicians and the hospital was directed by an Illinois trial court. It was claimed that the misdiagnosis subsequently made necessary the performance of a hysterectomy on the patient. The evidence failed to show any deviations from the accepted standards of practice in the treatment of extrauterine pregnancy, the court said.

Pugh v. Swiontek, Cir. Ct., Cook Co., Docket No. 61C-19515 (Ill., April 28, 1967).

Malpractice Insurer Not Liable to Physician Who Delayed Notifying Insurer of Claim—A trial court did not err in holding, in a declaratory judgment action, that a professional liability insurer was not liable to an insured physician with respect to a malpractice claim being litigated against the physician, where the physician had failed to give the insurer timely notice of the claim. The insurer did not, by taking control of the case, waive the lack of notice, a Florida appellate court ruled, since it did so under a written agreement with the physician that any action taken by the insurer in the case would not be construed as a waiver of its right to deny liability and withdraw from the case.

The physician performed a hysterectomy on the patient in January, 1964. In June, 1964, he performed an operation on her for an intestinal obstruction. Both operations were followed by substantial complications. On October 26, 1964, an attorney representing the patient wrote the physician a letter informing him that she was asserting a claim against him with respect to the two operations. The physician did not answer the letter and did not notify the liability insurer of it.

The patient filed suit on February 20, 1965. On April 1, 1965, the physician notified the insurer that the suit had been filed. That was the first notice that the insurer had that the patient had asserted a claim against him.

The policy required the physician to notify the insurer as soon as was practicable after becoming aware of the assertion of a claim covered by the policy. After procuring, on April 12, 1965, a written agreement from the physician permitting it to investigate the claim and defend any suit connected therewith, without prejudice to any rights that it might have to deny liability and withdraw from the case, the insurer took control of the suit. At various times after taking control of the suit, the insured served reservation of rights letters on the physician, presumably for the purpose of making it clear to him that it considered the nonwaiver agreement to be still in effect. After having moved, on December 10, 1965, to be permitted to withdraw as counsel for the

physician, the insurer filed this declaratory judgment action.

The physician's failure to notify the insurer when he first learned of the patient's claim constituted a material breach of the policy's terms. The patient claimed that she had sustained damages of such severity as to require early and thorough investigation. By assuming control of the patient's suit against the physician, the insurer did not waive its right to assert the physician's breach of the policy provision as to the giving of notice. Although there may be cases in other jurisdictions to the contrary, the courts of Florida have held that acts done by an insurer, in handling a matter while a nonwaiver agreement with its insured is in force, do not constitute a waiver by the insurer of any right that it might have had to disclaim liability under the policy prior to the execution of the nonwaiver agreement.

Bergh v. Canadian Universal Insurance Company, 197 So.2d 847 (Fla., April 18, 1967; rehearing denied, May 12, 1967).

Refusal to Ban Interference with Krebiozen Distribution Upheld—A federal trial court's refusal to enjoin the AMA and others from interfering with the national distribution of the alleged cancer drug, Krebiozen, was upheld by a federal appeals court. Since no good-faith application for approval of the drug had ever been filed with the Federal Food and Drug Administration, the

court said it had no jurisdiction to act.

Physicians Liable for Death From Undiagnosed Peritonitis—

Damages could be recovered in a suit against two physicians by the widow of a deceased patient for having negligently caused his death from undiagnosed peritonitis. There was evidence from which the jury could find that the physicians were negligent in having failed to diagnose the patient's peritonitis and that their negligence was a proximate cause of the patient's death, the Colorado Supreme Court ruled.

The patient died a week after the physicians operated on him for the purpose of draining an abscess in his buttock in the region of the rectum. The expert medical witnesses agreed that the patient was suffering from liver trouble, peritonitis, and pelvic abscess at the time of his death, but they were not in agreement as to the cause of death. The widow contended that the cause of death was peritonitis and pelvic abscess, which the physicians negligently failed to diagnose. The physicians contended that hepatic coma which resulted from the failure of the patient's liver was the cause of death.

An expert medical witness for the widow testified that there were certain diagnostic aids, regularly used by skillful physicians, by which the patient's peritonitis could have been diagnosed if the physicians had used them. The witnesses for the physicians testified that they did not observe any symptoms that were inconsistent with their diagnosis of hepatic coma. There was competent testimony that the patient exhibited certain symptoms which indicated that a test for peritonitis should have been made. There was also evidence from which a jury could find that the physicians' failure to diagnose the patient's peritonitis was caused by their failure to properly attend him during the period that the condition was developing. The expert witnesses for the widow testi-

fied that early treatment for peritonitis would have saved the patient's life, while the physicians' expert witnesses testified that such early treatment would not have saved his life. The evidence raised questions of fact for the jury as to the issues of negligence and proximate cause, and the jury's determination of those issues in the widow's favor could not be interfered with, the court said.

The trial court properly overruled the physicians' objections to questions asked witnesses as to what the standard of care was in the taking of cultures. It was the theory of the widow's case that the physicians were negligent in misdiagnosing the patient's condition and there was testimony that the failure to take cultures of the original abscess was one of the factors that contributed to the misdiagnosis.

Artist v. Butterweck, 426 P.2d 559 (Colo., April 17, 1967; rehearing denied, May 8, 1967).

City Liable for Hospital Patient's Death—

In a suit for damages against the city for the allegedly wrongful death of a city hospital patient, the order of an intermediate appellate court, reinstating the jury's verdict against the hospital, was affirmed by the New York Court of Appeals.

The patient awoke about midnight complaining of a pain in his chest. His wife called a physician who, after examining the patient, made a diagnosis of acute myocardial infarction. He gave the patient an injection and called an ambulance from the city hospital.

When the patient was admitted to the hospital at 2:30 a.m., he was, according to the hospital record, suffering from chest pain and dyspnea. The ward physician prepared an order sheet containing 12 items of care for the patient, eight of which, including an electrocardiogram and other diagnostic tests, were not administered. Oxygen was neither prescribed nor administered until about

1:15 p.m. when the patient became cyanotic and stopped breathing. He was pronounced dead at 1:20 p.m. The cause of death was coronary occlusion.

The administratrix of the patient's estate contended that the city was negligent in the following respects: in its transportation of the patient to the hospital, because he was required to undergo the exertion of dressing and walking downstairs to the ambulance; in not providing the care specified on the ward physician's order sheet; in not administering oxygen until the patient stopped breathing. An expert medical witness for the administratrix testified that the city did not perform its duties in accordance with accepted standards and that its negligence was the competent producing cause of the patient's death. In the order which was here affirmed by the Court of Appeals, the intermediate appellate court said that the evidence raised questions of fact for the jury and supported its verdict in favor of the administratrix.

Schempp v. City of New York, 279 N.Y.S.2d 183 (N.Y., March 2, 1967).

Nursing Home Liable to Visitor

Injured in Fall—In a suit against a nursing home by a 77-year-old visitor for injuries sustained when she fell on the steps at the home's entrance, the visitor was awarded damages of \$7,500 by an Illinois trial court jury. There was evidence that, at the place where the visitor fell, the steps were not equipped, as was required by a city ordinance, with a handrail. The visitor presented evidence that the fall occurred at 6:45 p.m. on March 1 and that the steps were not lighted. The home presented evidence that the fall occurred an hour earlier, when it was still light.

Dwyer v. Beacon Hill Nursing Home, Cir. Ct., Cook Co., Docket No. 64 L 15692 (Ill., May 23, 1967).

VA Issues Rules on Defense of Malpractice Cases—

The Veterans

Continued

BREAK A DIET CYCLE, TODAY.

On-again, off-again dieting is the worst kind.

On the 8th day of most "7-day diets," people are too busy eating to tell you how much they lost.

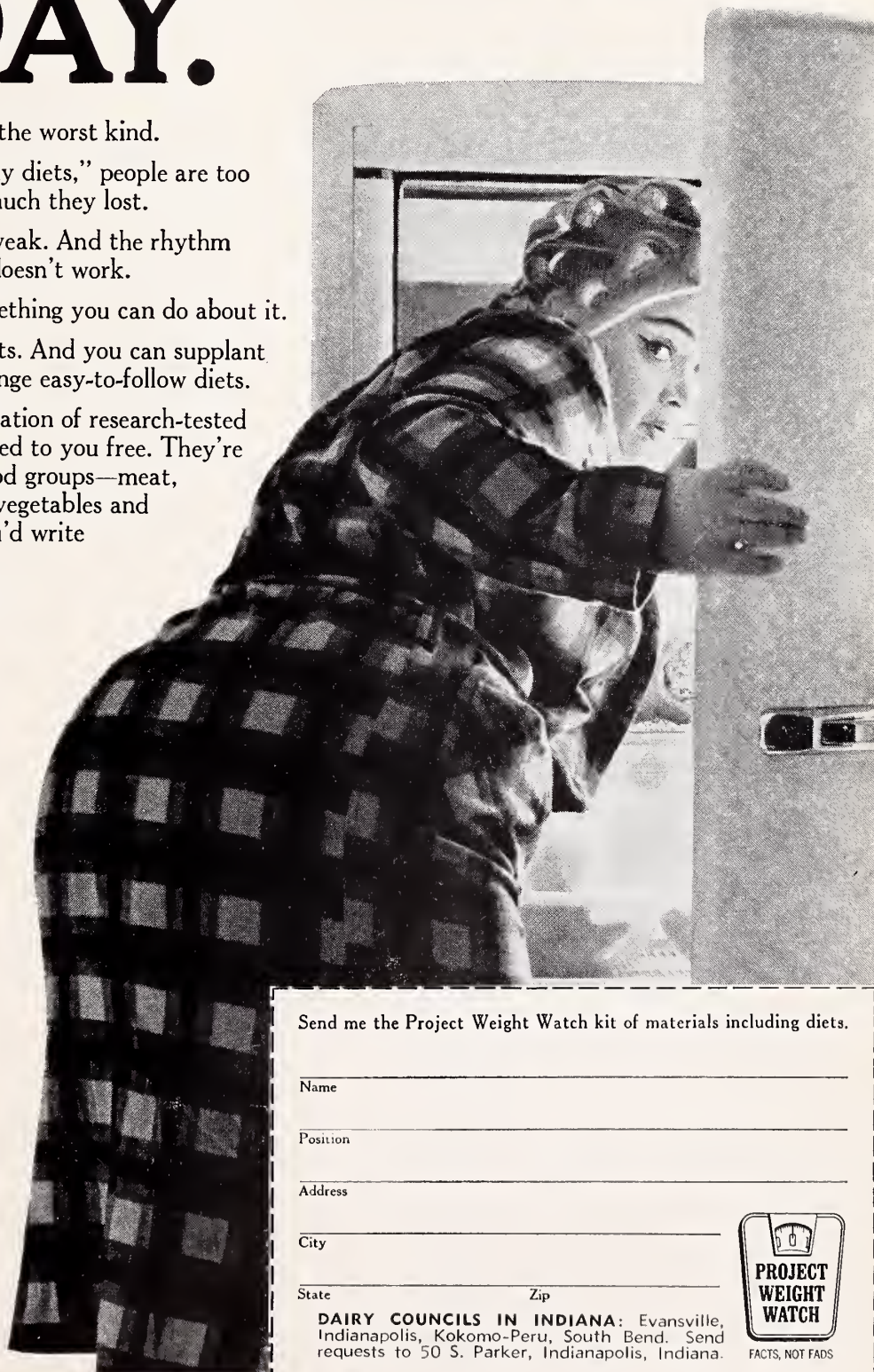
It's just that week diets are weak. And the rhythm method of girth control just doesn't work.

As a professional, there's something you can do about it.

You can replace fads with facts. And you can supplant short-term plans with long-range easy-to-follow diets.

That's what prompted preparation of research-tested scientific diets which are offered to you free. They're a realistic balance of the 4 food groups—meat, bread and cereals, fruits and vegetables and dairy foods. They're diets you'd write yourself if you had the time.

Send for them. Fasts are slow ways to lose weight.



Send me the Project Weight Watch kit of materials including diets.

Name

Position

Address

City

State Zip

DAIRY COUNCILS IN INDIANA: Evansville, Indianapolis, Kokomo-Peru, South Bend. Send requests to 50 S. Parker, Indianapolis, Indiana.



Administration has issued regulations implementing a recent federal law barring malpractice suits against Veterans Administration physicians unless the claim has first been submitted to, and denied by, the Veterans Administration. Under the new law, an amendment of the Federal Tort Claims Act, federal agencies are, for the first time, authorized to process and settle claims arising out of the Act. Covered by the new law and regulations are claims alleging malpractice or negligence in furnishing medical care and treatment by physicians, dentists, nurses, pharmacists, and paramedical and other supporting personnel in the VA's Department of Medicine and Surgery. The requirement that such claims first be submitted to the agency applies to claims arising on or after January 18, 1967. Under the revised regulations, the VA has delegated to the Chief Attorneys in its regional offices the authority to process and settle claims not exceeding \$2,500.

Public Law 89-506, Sec. 5(b), amending section 4116, title 38, U.S. Code; *VA Regulations* 6 (E), 5514.1 and 5611-5613.

American College of Surgeons Tax-Exempt as Charitable Organization — The American College of Surgeons was entitled to an order enjoining the county treasurer from collecting taxes on its property, where there was sufficient evidence to support the finding that it was a charitable organization, the Illinois Supreme Court ruled.

The College maintains a library and museum, both open to the public, and has a library of surgical films which it loans to interested groups. It has a program devoted to the various aspects of the problem of the entire management of the cancer patient in the hospital, and a program dealing

with the prevention and treatment of traumatic injuries, which program includes a short course in emergency treatment for selected non-medical groups. It is a member of the Joint Commission on the Accreditation of Hospitals. It has a scholarship program, publishes a journal, and conducts scientific and educational programs. It conducts no programs relating to the economics or business aspects of the practice of surgery and engages in no lobbying or political activities. More than one-half of its income comes from its members in the form of dues and fees. Donations from public and private sources comprise the remainder of its income.

The use to which an organization puts its funds is of more importance than the source of the funds in determining whether the organization qualifies as a charity. Although many of the programs conducted by the College are attended primarily by members of the medical profession, it makes its benefits available to the public to the greatest extent possible. Its library and publications, and its training, educational, and accreditation programs to some extent relieve the state's burden of advancing the interests of its citizens. A consideration of all the evidence showed that the College's property was used for charitable purposes, the court said.

American College of Surgeons v. Korzen, 224 N.E.2d 7 (Ill., Jan. 19, 1967).

Compensation Benefits Denied Because of Claimant's Refusal of Surgery — The denial of benefits, under the Workmen's Compensation Act, for the disability of the claimant's hand was proper, where the evidence supported the finding that his refusal of corrective surgery on the hand was unreasonable, the Court of Appeals of Maryland ruled.

The test for determining whether a claimant's refusal of surgery is rea-

sonable is whether a reasonably prudent man would be expected to undergo it. The claimant's own fears and beliefs, as such, have no bearing on the matter. The chance of success and the benefit to be gained must be weighed against the risk to life and health and the pain and inconvenience involved in the procedure. The evidence was undisputed that the operation, if successful, would substantially improve the claimant's condition, although there was a conflict in the evidence as to the possibility of success. There was no evidence that the operation involved any risk to life or was particularly dangerous. Any inconvenience from the operation would be moderate and of short duration.

Watts v. J. S. Young Company, 225 A.2d 865 (Md., Jan. 27, 1967).

Orthopedist's Heart Attack Not Compensable Accident — An orthopedist was not entitled to recover benefits, under the Workmen's Compensation Act, for disability caused by a myocardial infarction which he suffered while at work, the Colorado Supreme Court ruled. The orthopedist claimed that the infarction was caused by overwork and overexertion while his associate was on vacation. The evidence showed that his work at that time was, on the whole, little different from his usual routine. A medical expert testified that the orthopedist had a heart condition of long standing and that he could find no causal relation between the orthopedist's work while his associate was on vacation and the myocardial infarction which he suffered. The evidence was sufficient to support the Commission's denial of the orthopedist's claim, the court said.

Markheim v. Rocky Mountain Orthopedic Clinic, 422 P.2d 49 (Colo., Jan. 3, 1967; rehearing denied, Jan. 23, 1967).

BOOK REVIEWS

PHARMACOLOGY IN MEDICINE

Victor Drill, M.D., Ph.D., edited by Joseph R. DiPalma, M.D., 3rd edition, McGraw-Hill Co., New York City, 1965; 1488 pages with innumerable tables and figures.

This overdue revision of a post-World War II text that is already a recognized classic has a new editor working with almost 100 chapter authors; almost two thirds of them are new. Physically, the publishers have actually managed to *decrease* the bulk of the volume while still using paper that is not too fragile for the expected heavy usage.

The individual chapters are almost uniformly crisply concise, informatively up-to-date and didactically clear without being stuffy. The first 80 pages are devoted to "Modern Approaches to Pharmacology." I read this innovation through in its entirety; I benefited greatly from the careful perusal as, I'm sure, you will.

This year, I've had the precious privilege of reviewing several recent new editions of classics in the field of medicine and areas ancillary to it. More and more, I'm being imbued with the crystallizing opinion that we are at a watershed marking more than just the close of the second third of the century and the opening of the final third. The chaotic churning produced by the enormous knowledge explosion following World War II is beginning to form new patterns outlining new approaches to basic thinking as to the etiology and therapy of diseases. Almost as Pasteur and Lister made everything preceding them obsolete, so is the integration of the revolutionary newer concepts making totally obsolete the knowledge acquired by medical students a mere couple of decades ago. The intern of today is taught items unknown to his predecessor. The older man simply HAS to keep up. He is in peril of becoming just another old codger if he fails to make the effort!

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

CASTE AND RACE

Ciba Foundation Symposium, edited by Anthony de Reuck and Julie Knight, Little, Brown & Co., Boston, Mass., 1967; 347 pages; \$12.00.

This is one of those volumes instructing us (yet again) in how little we really know. The *comparative approaches* taken by the almost two dozen participants probe in depth topics of which I *thought* I had some comprehension. I was introduced to the "Tokushu Burakumin"—people of special communities in Japan. I got perception in depth of the pariahs of India as in other lands. Let me quote and have the lecturers speak for themselves.

On p. 155, discussing "Pariah Castes Compared," we read, "The stereotype of one form is rooted in *super-ego* concerns and is pictured as mercenary, ambitious, cunning and clannish. These stigmata are readily attached to alien merchant groups such as Jews in medieval Europe, Chinese merchants in Indonesia or the Muslim Indians of East Africa. The other stereotype, based upon *id* projections, is seen as lazy, ignorant, dirty and depraved; into this category fall the American Negro, the European gypsy and the Japanese Burakumin."

On pp. 194-195, we read that "In North America, race is defined in an extremely unsubtle and unimaginative way . . . In Latin America, a complex terminology was developed for an

almost infinite variety of gradation from pure white to pure black. . . . It is ironic to note that this very stratification was a powerful factor in mitigating the inhumanities of slavery."

And then, on p. 253, while discussing "The Myth of Jewish Conspiracy," we read, "Yet, however whites may see Negroes, they can hardly see them as father figures, 'good' or 'bad.' The fantasy of an infinitely powerful, world-dominating conspiracy does not in fact get projected on to Negroes and that may well account why not even the most fanatical Negro-haters dream of genocide. In the most dangerous form of anti-semitism, Jews are seen above all as 'bad parents'; this makes them seem so overwhelmingly powerful that the only way to cope with them is to destroy them utterly." I know of no better analysis for the tenacious survival of the myth anent the Protocols of Zion. The Jew is identified "with the 'bad' (rebellious, parricidal) son but, still more, with the 'bad' (castrating, torturing, poisoning) parent."

There are numerous other quotes I could make but I hope you get the idea. It is a splendid analysis of some of the basic malaise afflicting our society. I can recommend this for all intelligent readers who are desirous of comprehending of "just what gives."

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

RHEUMATIC AND CORONARY HEART DISEASE

Symposium edited by Charles P. Bailey, M.D., Lippincott Co., Philadelphia, Pa. 1967; 304 pages; 157 illustrations; \$15.50.

This relatively slim and modestly priced volume presents the essence of a medical-surgical symposium sponsored by St. Barnabas Hospital, New York City. The gathering lasted three days; more than a score of distinguished leaders in the field gave formal essays and then participated in the panel discussions.

Dr. Bailey did an outstanding feat of condensing and clarifying the truly colossal amount of material: much of it new and unobtainable elsewhere. The final product is like that proverbial lady's skirt: it covers all the points of importance and yet is short enough to be interesting!

The illustrations are superb; the paper, binding and printing is first class; I did not come across any typographical errors. Unhesitatingly, I recommend this as a prize to be added to all hospital libraries. Most physicians would do well to ensconce it on their working shelf: it will bear repeated readings, almost at random. Admitting that the specific area is changing with vertiginous speed, it is still sobering to realize how much of the new had passed me by until I read about it in this magnificent symposium!

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

POTENTIATION OF ANTICOAGULANT EFFECT OF WARFARIN BY PHENYLBUTAZONE

P. M. Aggeler et al. (Medical Services, San Francisco General Hosp., San Francisco)

New Eng. J. Med. 276:469-501, (March 2), 1967.

After a preliminary period of treatment with phenylbutazone, warfarin was administered to three normal subjects and one patient with hereditary resistance to the prothrombinopenic effects of coumarin anticoagulant drugs. A correction was made for the

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

SYNIRIN is another
pharmaceutical achievement



W.M. P. POYTHRESS & CO., INC.

RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Synirin®

ACETYSALICYLIC ACID (ASPIRIN)..... 5 GR.

*PENTOBARBITAL (ACID)..... 1/8 GR.

*Warning: may be habit-forming

ABSTRACTS, BOOKS

Continued

effect of phenylbutazone in the measurement of warfarin in the plasma. Results were compared with similar experiments in which phenylbutazone was not administered. When phenylbutazone was given, the plasma concentration and the biological half-life of warfarin decreased significantly but the anticoagulant effect increased markedly. Equilibrium dialysis experiments showed that phenylbutazone displaced warfarin from human serum albumin binding in vitro. Phenylbutazone probably potentiates the action of warfarin in vivo by displacing warfarin from its binding to plasma albumin.

THE SUBCLAVIAN STEAL SYNDROME

Dr. D. A. Killen et al. (Department of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.)

Amer. Surg. 33:128-138, (Feb.), 1967.

Occlusion of the subclavian or innominate artery, proximal to the origin of the vertebral artery, results in flow of blood from the ipsilateral vertebral artery into the distal subclavian artery. This situation results in "stealing" of blood from the basilovertbral axis to supply the shoulder and arm. The diagnosis of subclavian steal syndrome has been established by arteriographic studies in 20 patients. Neurologic symptoms were present in 14 patients; symptoms of arterial insufficiency of the involved arm were present in 8. In 12 patients neurologic symptoms consisted of transient ischemic episodes only. Delineation of the responsible occlusive arterial lesion and documentation of reverse vertebral artery flow were based on the findings at thoracic aortography in each patient. Atherosclerotic occlusive disease was the etiology in 18 patients. Operative revascularization of the obstructed artery responsible for the reversal of vertebral artery flow was attempted in 18 cases; arterial reconstruction was successfully accomplished in 17. The reconstructed artery has remained patent in 14 patients.

ANTIFERTILITY PROPERTIES OF TWO NON-ESTROGENIC STEROIDS AND MRL 37

C. W. Emmens et al. (Department of Veterinary Physiology, University of Sydney, Sydney, Australia)

Steroids 9:235-243, (Feb.), 1967.

Three antiestrogenic compounds showing no estrogenic activity by vaginal smear tests at high dosages in mice exhibit contrasting antifertility actions. The steroid, SAP 104, which has no other known actions but antiestrogenicity, prevents mating but not pregnancy if given after mating. Another steroid, U-10997, prevents mating, also prevents pregnancy if given after mating, and acts maximally during days one to three after mating. It is androgenic and anabolic. The nonsteroidal MRL 37 does not prevent mating in doses up to 1 mg./day, but at that dose prevents pregnancy even if administration is stopped at mating. It is also effective when given after mating at a similar dosage level on days one to three or four to six.

MICROWAVE OVEN RADIATION HAZARDS IN FOOD-VENDING ESTABLISHMENTS

H. J. Suroviec (Meadville, Pa.)

Arch. Environ. Health 14:459-462, (March), 1967.

Microwave ovens used in food service establishments were monitored with an electromagnetic radiation detector to determine if operators were exposed to hazardous microwave intensities. Ovens in self-service vending and other food service establishments were evaluated. The results indicated leakage around the periphery of the doors and through door grills which presents a potential hazard.

INTRANASAL FREEZING FOR SEVERE EPISTAXIS

C. C. Bluestone (3500 Fifth Ave., Pittsburgh) and H. C. Smith
Arch. Otolaryng. 85:445-447, (April), 1967.

Intranasal freezing has been highly successful in the emergency control of severe epistaxis in 21 patients. There was only one recurrence in the immediate postfreeze period, and there were no serious complications. During a one-year follow-up, no significant sequelae were noted, but all patients with hereditary telangiectasia have had recurrence of epistaxis. The procedure has been found to be safe, technically simple, effective, and well tolerated by the patients.

THE VALUE OF TWO MILLIVOLT ROENTGEN-RAY THERAPY IN DIFFERENTIATED THYROID CARCINOMA

M. I. Smedal, F. A. Salzman, and W. A. Meissner (Department of Pathology, New England Deaconess Hospital, Boston)
Amer. J. Roentgen. 99:352-364, (Feb.), 1967.

Papillary and follicular carcinoma of the thyroid is radiosensitive. The survival rate of 82% for five years in surgically nonresectable cases using external radiation as the prime modality was equal to the results with radical surgery plus megavolt external radiation. The high five-year survival rate in the limited number of cases in stage I and stage II suggests that the radical surgery is not necessary. Better results are obtained with super-voltage than with orthovoltage radiation, because it is possible to deliver twice the dosage with fewer reactions.

TREATMENT OF HEMOPHILIA (FACTOR-VIII DEFICIENCY) WITH HUMAN ANTIHEMOPHILIC FACTOR PREPARED BY THE CRYOPRECIPITATE PROCESS

C. R. M. Prentice et al. (Royal Infirmary, 86 Castle St., Glasgow)
Lancet 1:457-460, (March 4), 1967.

A plasma fraction rich in antihemophilic factor (AHF) made by the cryoprecipitate process has been evaluated in the treatment of 11 bleeding episodes in eight hemophilic patients. In vitro assay of the material as diluted for infusion showed the average bag of cryoprecipitate contained 113 units of AHF, but there was a great deal of variability. The activity of cryoprecipitate after infusion into patients was, on average, 81% of the in vitro activity. Three hundred ninety-three precipitates were used for the treatment of the 11 bleeding episodes. This material could be made easily by the hospital blood bank, and no other supplies of AHF concentrate were needed once a stock of precipitates had been built up. After the extraction of AHF, the whole blood was used for most routine blood-transfusion purposes. No serious complications arose from the use of the material.

SUCCESSFUL USE OF THE MILLER-ABBOTT TUBE

M. Deitel
Canad. J. Surg. 10:245-257, (April), 1967.

A two-year record was kept, during which intestinal intubation was successfully accomplished in 98.3% of 369 patients. Pre-operative deflation of small bowel facilitates elective small and large bowel surgery, particularly in presence of multiple adhesions, and it has application in gynecologic and abdominal aortic surgery. Postoperative decompression is accomplished. The inflatable-

removes the mental blur



that clouds vision

SOLFOTON®

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID® (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy
A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.
Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s

Solfoton Capsules (yellow and brown)
100s, 500s, 1000s

Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

deflatable balloon permits control over location. Nonstrangulating obstructions may be relieved early; late obstructions require a tube with larger lumen. Patency is maintained readily with Caroid solution. In 44 admissions for intestinal obstruction, no failure in passage occurred. Use of the M-A tube in repair of huge hernias, identification of site of bleeding, and radiological delineation of small bowel tumors is also shown. In the majority of the cases the tube was used for elective major surgery. Post-operatively, no patient required surgery for intestinal obstruction.

ABNORMAL URINARY STEROID EXCRETION AND SUBSEQUENT BREAST CANCER

R. D. Bulbrook and J. L. Hayward (Department of Surgery, Guy's Hospital, London)

Lancet 1:519-522, (March 11), 1967.

A prospective study of a normal population was undertaken to investigate a possible association between abnormal urinary hormone excretion and the subsequent development of breast cancer. Over five years, 4,850 24-hour specimens of urine were collected from women between the ages of 35 and 55. Nineteen of these women have since developed breast cancer. The results show that in a substantial proportion of the cancer patients, the excretion of androgen (etiocholanolone) and corticosteroid metabolites (17-hydroxycorticosteroids) was abnormal. The abnormality was multidirectional and, when compared with controls, tended to deviate further from the control mean values than did the individual controls. This deviation was statistically significant.

BILATERAL CARCINOMA OF THE BREAST

J. G. Shellito and W. C. Bartlett (3244 E. Douglas, Wichita, Kan.)

Arch. Surg. 94:489-494, (April), 1967.

A survey of 292 patients with carcinoma of the breast was made. Twenty-two patients were found to have bilateral carcinoma of the breast; of these, three were simultaneous and 19 were nonsimultaneous. The criteria of Guiss were elected: (1) definite evidence that the first operation was for cancer; (2) a lapse of time over six months during which there was no evidence of recurrence; (3) development of an independent second primary in the other breast without evidence of metastases; (4) the clinical course of the patient after the second breast procedure was compatible with a second primary lesion. Mammography disclosed two otherwise undiscovered carcinomas. Conclusions were: bilateral breast carcinomas are more often due to primary tumor formation than to metastases from the first breast cancer; mammography is advised in the follow-up examination of the remaining breast; bilateral nonsimultaneous breast carcinomas occur in 6.5% and simultaneous bilateral carcinomas in 1% of all breast cancer patients.

AGRANULOCYTOSIS AND JAUNDICE ASSOCIATED WITH CHLORPROMAZINE

E. M. Cheongvee, L. Hurst, and R. H. F. Smith (Severalls Hospital, Colchester, England)

Brit. J. Clin. Pract. 21:95-96, (Feb.), 1967.

A case of agranulocytosis with jaundice associated with chlorpromazine medication in a mentally subnormal youth aged 17 is reported. The agranulocytosis produced symptoms after eight days of medication and jaundice appeared clinically 11 days after the drug had been started and three days after it had been stopped. The patient had been given chlorpromazine for a period of 92 days, some weeks previously. Prednisolone, gamma globulin, cloxacillin, and tetracycline were given and the patient recovered. Routine leukocyte counts are held to have no place in the early recognition of agranulocytosis. ◀

Butazolidin®, phenylbutazone
In Acute Superficial Thrombophlebitis

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Acute Superficial Thrombophlebitis: Initial: 6 capsules or tablets daily in divided doses for 2 or 3 days. Maintenance: 3 capsules or tablets daily. Usual duration of therapy is 5 to 7 days (rarely beyond 10 days). 6509-V(B)R2

*Stein, I.D.: Presented at the American Academy of General Practice, Dallas, Sept. 1967.

For complete details, please see full prescribing information.

it used to take weeks



Acute superficial thrombophlebitis before treatment



After 5 days of Butazolidin therapy

In acute superficial thrombophlebitis, patients were usually bedfast for 2 to 4 weeks, tying up hospital beds, requiring costly nursing care and time-consuming procedures such as warm soaks and packs.

When Butazolidin was added to the usual regimen, 960 of 1000 patients obtained complete resolution; most required only 30 capsules or tablets; relief of pain and discomfort and regression of inflammatory signs and fever occurred within a few days.*

Side effects occurred in 6% of the 1000 patients. While none were serious or long-lasting, Butazolidin can produce severe side effects in rare instances. Further, not every patient can take Butazolidin. Therefore, select patients with care and follow them closely. Contraindications, Warning, Precautions and Adverse Reactions are summarized in adjacent column.

Butazolidin gets bedfast thrombophlebitics out of bed, fast. Usual duration of treatment is 5 to 7 days, and rarely exceeds 10 days. Try it and see. For full details, please refer to the complete prescribing information.

Butazolidin[®] alka

Capsules:
phenylbutazone, 100 mg.; dried aluminum hydroxide
gel, 100 mg.; magnesium trisilicate, 150 mg.; hom-
atropine methylbromide, 1.25 mg.

Butazolidin[®] phenylbutazone

Tablets of 100 mg.

Geigy



Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.^{1,2} For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle...there is no alternative or substitute for absolute bed rest..."³

2 Board "Boards should be ordered under the mattress...these boards act by immobilizing the spine..."⁴

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."⁵

4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated⁶ skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."⁷ And there is little likelihood of sedation.⁶

Indicated for relief of skeletal muscle spasm. Contraindicated in hypersensitive patients. Side Effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. Also available: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A-H-ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220



American Medical Writers' Association Presents Annual Awards

The American Medical Writers' Association, at its annual meeting in Chicago recently, awarded its "Honor Award" to Dr. Loyal Davis of Chicago, editor of *Surgery, Gynecology and Obstetrics*, for his distinguished contributions to medical communication.

The "Harold Swanberg Distinguished Service Award" went to Dr. C. Howard Ross of Ann Arbor for distinguished contributions to medical literature and distinguished service to the medical profession. The "President's Award" was presented to Miss Alvina Rich Lewis, managing editor of *The New York State Journal of Medicine*, in recognition of her outstanding service to the association and her devotion to its principles.

The association's "Honor Award in Medical Journalism" went to *The New England Journal of Medicine* in recognition for its Medical Progress series. The 1967 "Honor Award in Medical Communication" was presented to *Science*, the journal of the American Association for the Advancement of Science, in recognition of a series of editorials and articles on current developments in medicine.

Dr. Bowers Honored

Dr. Charles R. Bowers, Anderson, recently was named recipient of the Liberty Bell Award, presented annually by the Madison County Bar Association. The award is given in recognition of "community service which strengthens the effectiveness of the American system of freedom under law."

Dr. Bowers is the only doctor from Indiana and one of the few in the entire United States who has served two tours of duty in Viet Nam.

American Association of Medical Assistants Honors Indiana Members

The American Association of Medical Assistants, at a recent annual convention, awarded the designation "Certified Medical Assistant" to two of their members from Indiana, Janeta B. Gayer, Terre Haute and Dorothea H. Henry of New Albany.

The honor is achieved by satisfactorily passing a rigid examina-

tion. Only those members who have graduated from high school, are at least 21 years of age and have a minimum of three years of employment by a licensed M.D. are eligible for examination. Seventy-four medical assistants were so designated nationally this year.

Dr. Schmitt Assumes Post

Dr. Robert J. Schmitt, Munster, has been named director



CERTIFIED
*prosthetic
technicians in
over 30 cities*

Every HANGER office offers the services of Prosthetic Appliance Technicians approved by the American Board for Certification in Orthotics and Prosthetics as "Certified Prosthetists." Each of the more than 30 offices provides one or more Prosthetic Appliance Technicians.

These are more "certified" facilities and technicians than offered by any other manufacturer. "Certification" plus Hanger's complete line of arm and leg appliances for all types of amputations, guarantees every doctor an excellent chance for the successful rehabilitation of his amputee patients.

Hanger
PROSTHETICS

1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 Pontiac St., Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711



The relief received from the first Trocinat 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinat 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

NEWS NOTES

Continued

of the Adult and Child Guidance Clinic of LaPorte County.

U.S. Public Health Service Offers Free, Short-term Loan Films

The U. S. Public Health Service has for free short-term loan the following motion picture films:

1. "The Watch on Health"—a 16 mm., sound, color 13½ minute film with the purpose of recruiting personnel for the Public Health Service, to orient new employees and to document the history and activities of the Service. The film is suitable for medical and paramedical personnel.

2. "Rapid Frozen Section Techniques"—a 16 mm., color, sound, 5½ minute film to train hospital medical technologists in a rapid method of preparing tissue. Suitable for technician trainees.

3. "Strokes"—16 mm., black and white, sound, 59 minutes is a panel discussion on cerebral vascular disease suitable for medical audiences. The symposium is entirely clinically oriented.

4. "Method for Rapid Electrophoresis"—16 mm., color, sound, 11½ minutes—to train hospital medical technologists in the use of an electrophoretic apparatus for rapid analysis of serum and other body fluids. Suitable for technician trainees.

For free loan write Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Dr. Willison Appointed

Dr. George W. Willison, Evansville internist, was delegate to the 11th annual meeting of the American Society of Internal Medicine held in San Francisco. He represented the Indiana Society of Internal Medicine.

Syntex Laboratories Establishes Speaker Service for Organizations

Syntex Laboratories has organized a Speaker Service and will furnish a lecturer, on request, for organizations both medical and non-medical.

Subject matter is concerned with overpopulation and inadequate food supply. Both of these problems and the control of insect pests have offered Syntex researchers a rewarding field for endocrinological investigation. For more information write the Syntex Speaker Service, Syntex Laboratories, Palo Alto, California 94304.

Dr. Deur Named

Dr. Julius J. Deur, Lafayette, has been named to a term on the Lafayette Board of Health and will serve until December 31, 1970.

Marion Laboratories Organizes New Doctor-Opinion Program

The opinions of 10,000 American physicians will be sought, collected and collated by a new doctor-opinion program which was started by Marion Laboratories in September.

Each month a 12-minute record is recorded by N.B.C. news analysts to cover world-wide news of political and social significance. Marion will mail one of these records to each of 10,000 physicians chosen principally from those in general types of practice.

Each recipient will be asked to answer five or so questions after he has listened to the news-record. The answers will be analyzed state by state and nationally to produce a report of doctors' opinions on matters of political, economic and social importance.



THE COUNCIL met in session in the Board Room of the American Medical Association building on September 17. The Council and their guests had toured the AMA headquarters the day before. Dr. F. J. L. Blasingame, executive vice president of the AMA, addressed the Council on the activities of the AMA, after luncheon.

Dr. Montgomery Speaker

Dr. Lall G. Montgomery, Muncie, was guest speaker at a recent meeting of the Delaware-Blackford County Medical Association's 11th annual state convention. Dr. Montgomery is national president of the American Society of Clinical Pathologists.

Consumer Price Index for Prescription Drugs Drops Again

The U.S. Department of Labor has disclosed that its Consumer Price Index for prescription drugs dropped one-and-a-half percent in the first six months of this year to a record low of 88.8. This means that drugs which cost five dollars in the 1957-59 base period of the index were down to \$4.40 by the middle of 1967. During the same period the index measured a 16% increase in "all items" of consumer purchases. The latest drop in drug prices is attributable to substantial reductions by manufacturers, wholesalers and retailers in the prices of drugs which fight infections—down 8.1% in the past 12 months and 31.9% since 1960.

Dr. Ringer Elected

Dr. William A. Ringer, Attica, has been elected to active membership in the American Academy of General Practice.

Arthritis Foundation Publishes New Booklet on Osteoarthritis

"Osteoarthritis, A Handbook for Patients," is a 20-page booklet published by the Arthritis Foundation to explain in simple terms what osteoarthritis is, how it causes trouble and what can be done about it. It may be obtained by doctors in single copies or in quantities for distribution to patients from the Indiana Chapter of the

Arthritis Foundation, 615 N. Alabama St., Indianapolis, or from The Arthritis Foundation, 1212 Avenue of the Americas, New York City 10036.

Dr. Sorrells Takes Course

Dr. George W. Sorrells, Bedford pediatrician, recently took a four-week intensive course at the University of Colorado Medical Center in the management and care of premature and high-risk newborn infants.

PMA Completes Two New Self-Regulation Documents

The Pharmaceutical Manufacturers Association announces completion of two new documents designed to promote self-regulation by the members of the drug industry. Both are revisions of similar instruments which have been in effect for many years. One is a new and comprehensive "Code of Fair Practices," covering the advertising and promotion of prescription products. The other is entitled "General Principles of Total Control of Quality in the Drug Industry." It was adopted recently after being worked on for two years by a 15-man committee under the chairmanship of Stanley F. Kern of Eli Lilly & Company.

The new "principles" replace a 1961 "principles" which was used by the FDA, in large part, in preparing its 1963 regulations on "Good Manufacturing Practices." The major difference between the 1961 PMA principles and those announced recently is the emphasis given to "product design" as an essential part of the "total" concept of quality control.

Dr. Land Named

Dr. Francis Land has been chosen to head the recently elevated "Medicaid" program. All Title 19 administration was formerly carried out at a relatively low level in the Public Health

In Obesity,
anorectic action
with fewer unwanted
side effects



CYDRIL®
(levamfetamine succinate TUTAG)



Cydril at 2 p.m.
Appetite control at 6
Sleep at 10

Action and Uses: Cydril (levamfetamine succinate) is a chemopharmaceutical approach to aid the obstinately obese. Cydril (levamfetamine succinate) provides the appetite depressant action of amphetamines but exhibits fewer unwanted side reactions.

Dosage: Adults and 'teenagers', one (1) Cydril (levamfetamine succinate) Granucap* daily.

Side Effects: Occasionally cardiovascular and gastrointestinal reactions may produce dry mouth, metallic taste, anorexia, nausea, diarrhea, headache, chilliness, pallor or flushing, sweating, diuresis, and arrhythmias.

Contraindications: Cydril (levamfetamine succinate) should not be used in the presence of severe hypertension, angina pectoris, hyperthyroidism, and Raynaud's disease.

*Granucap is the Tutag brand of sustained release capsule manufactured to release the contents over a period of approximately 6 to 10 hours.

Caution: Federal law prohibits dispensing without prescription.

Full product information available on request or see page 1122 in your 1967 PDR.

For more about CYDRIL and the Cydril Family of Products ask the Man from Tutag (or, your colleagues)

S.J. TUTAG & CO. ETHICAL PHARMACEUTICALS
DETROIT, MICHIGAN 48234



NEWS NOTES

Service. It is now raised radically to the status of an "administration," and is titled "Medical Services Administration." Continued

Dr. Land is a former member of ISMA and resided in Fort Wayne.

Public Health Service Offers Film for Hospital Personnel

The Public Health Service has a 16 mm., color, sound, 7 minute training film for free short-term loan on the subject of cleaning hospital floors by the wet vacuum method.

It is useful to help train hospital personnel and to demonstrate methods of control of hospital infections. Write to Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

Dr. Rawlins is Speaker

Dr. Carolyn M. Rawlins, Munster obstetrician, spoke on "Happy Momma, Happy Baby" at a recent meeting of the Association for Childbirth Education in Munster.

Fort Wayne Groups Provide Undergraduates Clinical Training

The Fort Wayne Medical Society and the Lutheran, Parkview Memorial and St. Joseph's hospitals of Fort Wayne will provide the incentive and the clinical facilities for the first elaboration outside of Indianapolis, of the new program for the provision of clinical teaching for undergraduate medical students outside the Indianapolis campus.

Two senior medical students are in Fort Wayne this semester for preceptorship and "medical elective" training. Fort Wayne will also participate in the postgraduate and continuing medical education program of I.U. School of Medicine.

Dr. Philbrook Receives Award

Dr. Seth S. Philbrook, LaPorte, recently was honored by the LaPorte Lions Club for his volunteer medical work in eye bank surgery.

Dr. Lorman is Speaker

Dr. James G. Lorman, Fort Wayne, recently spoke at a meeting of the White Cross Guild of Parkview-Methodist Hospital on his experiences at the Mirage Medical Center in India. Dr. Lorman was sponsored by the First Presbyterian Church on a trip with his family to the Center.

Dr. Kress Conducts Program

Dr. James W. Kress, Muncie, recently spoke on self-examination for cancer at a meeting of the Muncie Soroptimist Club.

Dr. Given Speaks

Dr. Gilbert Z. Given, East Chicago, recently spoke on "The Total School Health Program" at a Lincoln School PTA meeting in East Chicago.

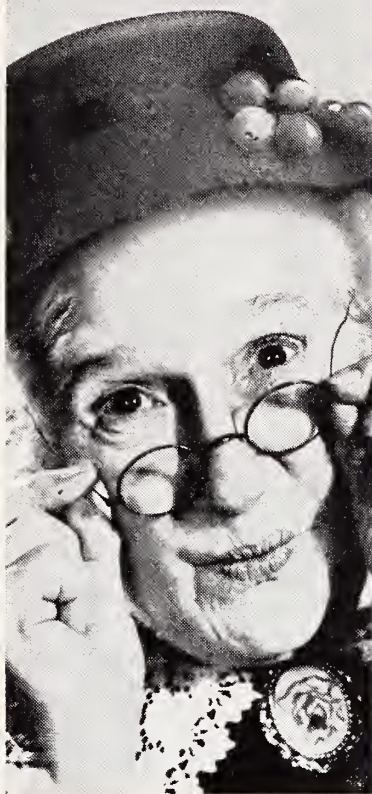
Dr. Holdeman is Speaker

Dr. Lillian S. Holdeman, South Bend, spoke on "Sex Education" at a recent meeting of the Columbia City Schools Parent-Teacher Association.

REFRACTOR



MRS. MURPHY



EVERYTHING

except
Mrs. Murphy

OFFICE CHAIR



comes from **WHITE-HAINES**

Her prescription lenses, of course! And the frames.
The refractor... the office chair.

Whatever you need... the finest optical and office
equipment... White-Haines will supply it.

We call it "depth of service".

We supply everything but the patient!

THE WHITE-HAINES OPTICAL COMPANY

Headquarters: Columbus, Ohio

Serving Ohio • Michigan • Pennsylvania • West
Virginia • Kentucky • Indiana • Illinois • Maryland

FUTURE MEETINGS, SEMINARS, COURSES

Eleventh Congress of Pan-Pacific Surgical Association October, 1969

The Eleventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu on October 14 to 22, 1969, following the meeting of the American College of Surgeons in San Francisco on October 6 to 10, 1969.

The scientific meetings in Honolulu will all be held in the morning. Some 300 speakers in all surgical specialties will lecture. Anesthesiology and radiology will be covered. Afternoons and evenings will be free for sightseeing and social events; families are urged to attend.

American Rheumatism Association Schedules Interim Scientific Session

The American Rheumatism Association will conduct an Interim Scientific Session at the Sheraton-Belvedere Hotel, Baltimore, on January 19 to 20, 1968.

The Association's Annual Meeting and Scientific Session will be at the Olympic Hotel, Seattle, on June 14-15, 1968. For more information write Miss Margaret Walsh, Exec. Sec., 1212 Avenue of the Americas, New York City 10036.

"Frontiers of Medicine, 1967-1968" Will Present Course on "Shock"

The third annual "Frontiers of Medicine" series will present

a course on "Shock" December 13 at the University of Chicago Hospitals and Clinics.

Further details on the programs and information on registration may be obtained by writing David M. G. Huntington, Administrative Coordinator, Committee on Continuing Medical Education, the University of Chicago, 950 E. 59th St., Chicago 60637.

"Ophthalmology" Postgraduate Course Listed for December 6-7

A postgraduate course in "Ophthalmology" will be conducted at the Cleveland Clinic Educational Foundation on December 6 and 7.

Further information and programs may be obtained by writing Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland 44106.

Association of Military Surgeons 74th Annual Meeting November 19-22

The Association of Military Surgeons will hold its 74th Annual Meeting on November 19-22 at the Sheraton-Park Hotel, Washington, D. C.

Society for Cryo-Ophthalmology Sets January, 1968, Meeting in Florida

The Society for Cryo-Ophthalmology will meet on January 14 to 18, 1968 at the Statler Hilton Plaza Hotel in Miami Beach.

Outstanding cryosurgeons from Europe, South America and the United States will lecture. Write Dr. John Bellows, Secretary, 30 N. Michigan Ave., Chicago 60602 for further information.

1968 American Industrial Health Conference in San Francisco

The 1968 American Industrial Health Conference will be held April 22 to 25 in The Hilton Hotel, San Francisco.

This is a joint meeting of the Industrial Medical Association and the American Association of Industrial Nurses. For further information write the American Industrial Health Conference, 55 E. Washington St., Chicago 60602.

Postgraduate Courses Offered By University of Colorado at Denver

The University of Colorado is offering two postgraduate courses in the near future of interest to general practitioners.

The first is a course on "Modern Concepts of Allergy" which will be given December 6-8. "Surgery of the Hand" is the second course, offered February 20-23, 1968. Further information and a detailed program may be obtained by writing: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver.

ESCORT YOURSELF . . .

to Home Lawn Mineral Springs
for a few days health vacation
—the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind.



HOME LAWN MINERAL SPRINGS

Martinsville, Indiana

M. C. Pitkin, M.D.
Medical Director

J. W. Gibbs, M.D.
Associate
Medical Director

Coming home is wonderful

when you have Blue Cross-Blue Shield

Here's a homecoming that was wonderful for everyone—thanks to Blue Cross-Blue Shield. From the instant recognition of the membership card at the hospital to the discharge later with virtually nothing to pay, this family appreciated their Blue Cross-Blue Shield service. Dad's boss had a good feeling about it, too—once again their group health care plan had paid off even beyond expectations. What's more, the boss didn't have to bother with claims-

filing and other administrative red tape.

Blue Cross-Blue Shield handles things directly with hospitals and with doctors—doesn't bother members or their bosses. That's one reason why employees *and* employers are so strong for it.

Actually, in these days of quality but higher cost medical care, you can't afford to be without the protection of Indiana's No. 1 health care plan. As they say around the happier homecomings—"I don't know what we would have done without Blue Cross-Blue Shield."

Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series
of ads being run
in key Hoosier
newspapers)

Deaths

John Eberwein, M.D.

Dr. John Eberwein, retired Indianapolis surgeon who performed the first operation at Methodist Hospital in 1908, died Sept. 16 at the age of 86.

A native of Jennings county, Dr. Eberwein was graduated from the former Indiana Medical College in 1907. He was formerly president of the Methodist Hospital staff and had been a member of the staffs of St. Vincent's, St. Francis and Marion County General Hospitals. He was also a former associate professor of surgery at the Indiana University School of Medicine and served in World War I. He was a Senior Member of ISMA, member of the 50-Year Club and the Marion County Medical Society.

Estle P. Flanagan, M.D.

Dr. Estle P. Flanagan, Walton physician for almost 60 years, died Sept. 16 at Kokomo. He was 84 and had just recently retired.

A graduate of Marion Normal College, Dr. Flanagan received his M.D. degree from the Louisville School of Medicine in 1908. He served in World War I at Fort Riley, Kan., and was an examining physician in World War II. He was a Senior Member of ISMA, a member of the 50-Year Club and the Cass County Medical Society.

C. Philip Fox, M.D.

Dr. C. Philip Fox, 69, Washington, Ind. physician, died Sept. 20 in Vincennes.

Graduated from the University of Illinois in 1924, Dr. Fox practiced at the Garrett Clinic and Huntertown, Ind. before going to Washington in 1933. Active in many organizations, Dr. Fox was charter director of Blue Cross-Blue Shield, member of the Board of Governors of the American Fracture Association and was a 20-year member of the selective service system. He was secretary of the Daviess-Martin County Medical Society for many, many years and a member of numerous committees and commissions of the ISMA. He was also a county delegate to the ISMA in 1966 and 1967.

Fred Gifford, M.D.

Dr. Fred E. Gifford, Indianapolis general practitioner for 46 years, died Oct. 3 at the age of 69.

An honor graduate of the Indiana University Medical School, Dr. Gifford began practice in Indianapolis in 1921. He was a World War I veteran, a staff member of Methodist and Winona Hospitals and a member of the Marion County Medical Society.

Thomas A. Gill, M.D.

Dr. Thomas A. Gill, 53, Muncie physician and surgeon, died Sept. 9 at his home.

A native of Michigan City, Dr. Gill had practiced at Muncie since 1946. He was graduated from the Indiana University School of Medicine in 1938, and served three years with the Army Medical Corps in Europe during World War II. He was a member of the Delaware-Blackford County Medical Society.

Wilbur L. Kenoyer, M.D.

Dr. Wilbur L. Kenoyer, colonel in the United States Air Force Medical Corps, died Aug. 5 at Scott Air Force Base, Ill. He was 48.

Graduated from the Indiana University School of Medicine in 1945, Dr. Kenoyer was deputy commander and director of education and training at the USAF hospital. Before his assignment to the air force base he was hospital commander at South Ruislip, London, England. Dr. Kenoyer was a member of the Marion County Medical Society.

Coen L. Lockett, M.D.

Dr. Coen L. Lockett, 75, long-time Terre Haute physician and surgeon, died Sept. 4 in Union Hospital there.

Dr. Lockett was graduated from Johns Hopkins University in 1917 and served as a lieutenant in France during World War I. He was very active in civic affairs in Terre Haute and was a fellow of the American College of Surgeons. He was a Senior Member of ISMA, a member of the 50-Year Club and the Vigo County Medical Society. He also served as an ISMA delegate and on various ISMA committees and commissions.

Martha Moore, M.D.

Dr. Martha Moore, 70, retired psychiatrist, died Aug. 29 at the Hanover Nursing Home.

A native of Shelby county, Dr. Moore was graduated from the Indiana University School of Medicine in 1929. She was doctor of internal medicine and psychiatry at Madison State Hospital for 21 years prior to her retirement in 1964. She also served six years on the staff at Muscatatuck State School and was a former member of the Jefferson-Switzerland County Medical Society.

William R. Morrison, M.D.

Dr. William R. Morrison, 78, retired Kokomo physician who practiced there 44 years, died Sept. 12.

A specialist in obstetrics and gynecology, Dr. Morrison was graduated from the Indiana University School of Medicine in 1918. He went to Kokomo in 1919. He served at one time as president of the Howard County Medical Society and at another period as Howard county coroner. In 1915, he was made a diplomate of the National Board of Medical Examiners, the first physician in Indiana to receive that honor. He was also on the medical staff at St. Joseph Memorial Hospital.

Walter S. Price, M.D.

Dr. Walter S. Price, 54, anesthesiologist at Indianapolis' St. Francis Hospital, died Aug. 10 at the Cleveland Clinic Hospital.

Graduated from the Jefferson Medical College, Philadelphia, in 1939, Dr. Price served in World War II and was a member of the Marion County Medical Society.

Clifford L. Williams, M.D.

Dr. Clifford L. Williams, retired Indianapolis psychiatrist, died Oct. 1 in Marion County General Hospital. He was 66.

Graduated from the Indiana University School of Medicine in 1926, Dr. Williams had been chief of acute intensive treatment and service at the VA Hospital in Marion. He was considered a pioneer in Indiana psychiatry. Before retiring last year, Dr. Williams was superintendent of Central State Hospital. He was a member of the Marion County Medical Society. ◀

Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL
ASSOCIATION CLINICAL
MEETING**

Date November 26-29, 1967

Place Houston, Texas

**AMERICAN COLLEGE OF SURGEONS,
INDIANA CHAPTER**

Date May 17-18, 1968

Place Stouffer Inn, Indianapolis

**INDIANA STATE MEDICAL
ASSOCIATION CONVENTION**

Date October 14-17, 1968

Place Fort Wayne

**NORTHERN INDIANA
PSYCHIATRIC SOCIETY**

Date Fourth Wednesday of every month,
September through June

Place For location and program, inquire
Beatty Memorial Hospital,
Westville

**INDIANA NEUROPSYCHIATRIC
ASSOCIATION**

Date Second Wednesday of the month,
October through May, excluding
December

Place The Athenaeum, Indianapolis

INDIANA ROENTGEN SOCIETY

Date May 5, 1968

Place Indianapolis

**INDIANA ACADEMY OF
GENERAL PRACTICE**

Date March 26-28, 1968

Place Indianapolis

**INDIANA ACADEMY OF OPHTHAL-
MOLOGY AND OTOLARYNGOLOGY**

Date May 1-2, 1968

Place Culver Inn, Culver

**INDIANA ASSOCIATION OF
PATHOLOGISTS, INC.**

Date December 2, 1967

Place Indianapolis Motor Speedway
Motel, Indianapolis

**INDIANA OBSTETRICAL AND
GYNECOLOGICAL SOCIETY**

Date January 10, 1968

Place Stouffer Inn, Indianapolis

**INDIANA PUBLIC HEALTH
ASSOCIATION**

Date April 30-May 1, 1968

Place Howard Johnson's Motor Lodge,
Indianapolis

**INDIANA SOCIETY OF
ANESTHESIOLOGISTS**

Date May 25-26, 1968

Place Marott Hotel, Indianapolis

**INDIANA STATE DENTAL
ASSOCIATION**

Date May 19-20, 1968

Place Murat Theater, Indianapolis



when he just can't sleep
Tuinal[®]

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, $1\frac{1}{2}$, and 3-grain Pulvules[®]**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206



700955

INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—September, 1967

Disease	Sept. 1967	Aug. 1967	July 1967	Sept. 1966	Sept. 1965
Animal Bites	1134	1091	1245	931	1144
Chickenpox	26	24	49	45	46
Conjunctivitis	43	47	98	62	105
Diphtheria	0	0	0	0	0
Dysentery, Unspecified	32	22	26	54	116
Gonorrhea	583	428	425	501	345
Impetigo	139	96	116	214	262
Infectious Hepatitis	33	32	23	41	42
Infectious Mononucleosis	41	8	33	46	63
Influenza	226	32	27	280	543
Measles					
Rubeola	5	7	21	37	40
Rubella	9	25	34	37	46
Meningitis, Meningococcal	4	0	1	5	2
Meningitis, Other	6	3	7	9	2
Mumps	82	142	261	53	58
Pertussis (whooping cough)	50	36	54	17	17
Pneumonia	99	92	109	86	260
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	301	250	220	312	549
Syphilis					
Primary & Secondary	15	16	13	7	5
All Other Syphilis	101	66	74	101	97
Tinea Capitis	11	0	6	3	21
Tuberculosis (Active)	85	63	70	88	82

★
Specialized Service

IN
PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

THE
MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller, Representative

665 East 61st Street

Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

From *The Journal* 50 Years Ago

. . . At the present time the Wassermann test is given by some men an exaggerated value and by others is looked upon with extreme skepticism. Between these extremes there is a happy medium that is at present attained by some and is the "consummation devoutly to be desired for all."

Three things are to blame for this wide variation of opinion; first, that many serologists have their individual pet methods (so-called improved methods) of performing the test and of reporting their findings; second, many clinicians are not as familiar as they should be with the significance of the reports they get, and third, there are too many "half baked" or embryo serologists whose unreliable work can do nothing but confuse the clinician and work harm for the patient.

. . . The writer believes most profoundly that there should be a standardized method for making and reporting Wassermann tests, so that the country over any given serologist's report would (or should) mean to the clinician exactly the same as any other serologist's report on the same serum when taken at the same time. As examples of this fault, in a recent number of *The Journal of Infectious Diseases*, there appeared a "Comparative study of Wassermann tests performed by six different methods on identical specimens," and which showed widely divergent results. . . . B. W. Rhamy, M.D., "The Wassermann Reaction," *JISMA*, November, 1917.

HARDING HOSPITAL, Inc.

(Formerly *Harding Sanitarium*)

WORTHINGTON

OHIO

For the Diagnosis and Treatment of Psychiatric Disorders

and with

Limited Facilities for the Aging

GEORGE T. HARDING, M.D.

Medical Director

JAMES L. HAGLE, M.B.A.

Administrator

Phone: Columbus 614-885-5381

County, District News

Eleventh District

A panel discussion on heart disease featuring Dr. Charles Fisch, Indianapolis, as moderator, highlighted the Eleventh District Medical meeting Sept. 13 at Logansport. Speaker at the dinner was Dean Clarence Manion. Dr. C. L. Wise, Camden, was elected president and Dr. Fred Poehler, La Fontaine, was re-elected secretary-treasurer.

Thirteenth District

New officers of the Thirteenth District Medical Society are: Drs. E. C. Mueller, LaPorte, president; John F. Kerrigan, Michigan City, president-elect and John O. Hildebrand, Jr., secretary-treasurer. Speakers on the program included Drs. George Bloom, Dana Troyer and J. G. Yoder, participants in the AMA-program of voluntary physicians for Vietnam; Dr. Ernest B. Howard, assistant vice president of the AMA; Mr. Robert E. Robinson, legal counsel for ISMA; Dr. Eugene S. Rifner, ISMA president and Mr. Harold L. Schuman, secretary and general manager of the Indiana Manufacturer's Association.

Adams

Mrs. Brown, president of the Adams County Tuberculosis Association, spoke at the Sept. 12 meeting of the Adams County Medical Society. A film on AMA retirement was also featured at the meeting.

Bartholomew-Brown

Dr. A. White, of the Indiana University Medical Center, showed a film on poliomyelitis at the Sept. 13 meeting of the Bartholomew-Brown County Medical Society. Thirty-six members attended.

Cass

A social hour and dinner in honor of Dr. and Mrs. Ernest Fogle, past-superintendent of Longcliff State Hospital, highlighted the Sept. 11 meeting of the Cass County Medical Society. Dr. Fogle is leaving to assume a position at the VA Hospital in Murfreesboro, Tennessee.

Gibson

Field Secretary Robert Amick met with the members of the Gibson County Medical Society Sept. 20 to urge attendance at the annual ISMA convention.

Jackson-Jennings

The Jackson-Jennings County Medical Society met Sept. 11 at Seymour to hear a clinicopathological conference. There were 18 members present.

Knox

A film on "Thyroid" was shown at the Sept. 19 meeting of the Knox County Medical Society. Twenty-six members attended.

Madison

Dr. Charles D. Swartz, professor of medicine at Hahnemann Medical College and Hospital, Philadelphia, spoke on "Ambulatory Management of Patients with Hypertension" at the Sept. 18 meeting of the Madison County Medical Society.

Miami

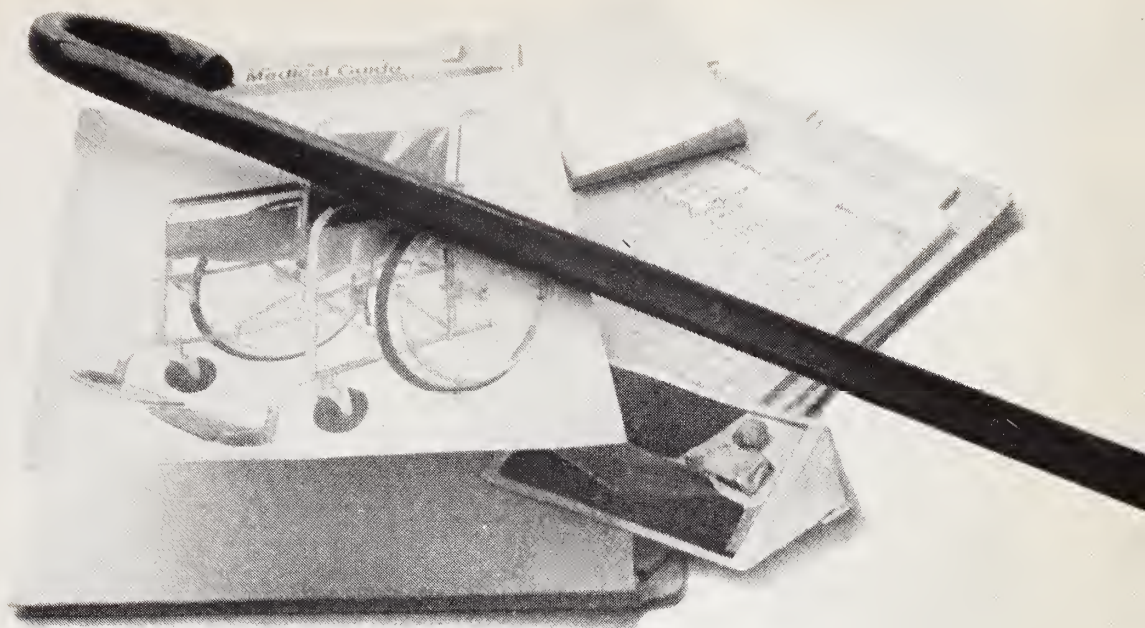
Eight members of the Miami County Medical Society met Sept. 19 at Peru to discuss upcoming resolutions at the ISMA annual convention and other society business.

Owen-Monroe

"Abdominal Pain in Children" was the topic chosen by Dr. Morris Green, of the Indiana University Medical Center, when he spoke at the Sept. 28 meeting of the Owen-Monroe County Medical Society.

Parke-Vermillion

Dr. Robert Carter spoke on "Urinary Infections in Children" at the Sept. 27 meeting of the Parke-Vermillion County Medical Society.



in chronic illness

B and C vitamins are part of therapy: An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS capsules, containing therapeutic quantities of vitamins B and C, are formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps[®]
Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (as Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

Association News

EXECUTIVE COMMITTEE

Sept. 16, 1967

Present: Ralph V. Everly, M.D., chairman, Burton E. Kintner, M.D., Eugene S. Rifner, M.D., G. O. Larson, M.D., Lowell H. Steen, M.D., Lester H. Hoyt, M.D.

Robert E. Robinson, attorney and James A. Waggener, executive secretary.

Treasurer's Office

The treasurer's report was given by the assistant treasurer and was approved on motion of Drs. Larson and Steen.

A letter of resignation from Doctor Olvey was read and on motion by Dr. Larson, seconded by many, the resignation was accepted and the secretary instructed to write Doctor Olvey thanking him for his loyalty and for his work as treasurer of the association.

Headquarters Office

A proposal from Pitney-Bowes for an automatic folder and stuffer was reviewed and on motion by Drs. Steen and Rifner, the secretary was instructed to purchase same.

Organization Matters

An exchange of correspondence between the headquarters office and the State Association of Medical Assistants was reviewed for the information of the committee.

A letter addressed to the president of the association from Dr. M. O. Rouse urging state associations to support PAC movements was read for the information of the committee.

A letter from the AMA concerning the publication "Patient Care" was reviewed.

A letter from the AMA urging the association to publicize the "Volunteer Physicians for Vietnam Program" was read for the information of the committee.

A letter from the AMA addressed to the governor of the state of Indiana was reviewed for the information of the committee.

A letter from the AMA acknowledging receipt of the nominations of Indiana physicians for positions on various AMA committees and councils was read for the information of the committee.

A request from the U. S. Treasury Department for the use of the mailing list for the purpose of mailing information to physicians on the U. S. Freedom Shares was reviewed and on motion of Dr. Steen and taken by consent, the request was denied.

A letter from the AMA concerning the use of certain phrases in the publication of the Indianapolis College for Medical Assistants was read for the information of the committee.

A request from the Commission on Public Information to present journalism awards to WTTV and *The Indianapolis News* was read and on motion of Drs. Steen and Rifner, the request was approved.

A letter from Robert J. Miller addressed to the State Insurance Commissioner was read for the information of the committee.

A resolution from the New York Medical Society concerning controlled panel practice was reviewed and on motion by Drs. Steen and Rifner this item was referred to the Council with the recommendation that the Council introduce a similar resolution at the meeting of the House of Delegates.

A letter from the president of the Allen County Medical Society, addressed to the chairman of the Council, was reviewed for the information of the committee.

A newspaper clip on firemen seeking some legalized protection of themselves during disaster uprisings, such as the Civil Rights riots, was reviewed for the information of the committee.

A letter from the chairman of the Council concerning the use of the letters "M.D." after the doctor's name on driver's licenses was reviewed and on motion of Drs. Steen and Larson, the association is to take this matter up with the Bureau of Motor Vehicles.

Annual Convention, Indianapolis — October 9, 10, 11 and 12, 1967

Entertainment program. Proposed budget. The budget for the entertainment program of the association was presented and on motion by Drs. Steen and Rifner, the committee was authorized a budget of \$1,750.00 over and above the cost of the Gaslight entertainment for putting on the Gaslight party and the committee was authorized to charge \$10.00 per person for admission.

The Journal

A proposal from Academic Archives, Inc., addressed to the editor of *The Journal* was reviewed and in the absence of the editor, on motion of Drs. Steen and Kintner, it was agreed to leave this decision to the editor.

Future Meetings

In reviewing the forthcoming meeting of the AMA, on motion of Drs. Larson and Steen, it was voted to conduct the meeting of the Executive Committee and the AMA delegates and alternate delegates at the Shamrock Hotel in Houston at 6:00 p.m. on Saturday, November 25.

A notice of the annual meeting of the Indiana State Chamber of Commerce to be held at French Lick October 12-14 was read and it was assumed that Dr. Don Wood, who would probably be in attendance at this meeting, could represent the association at this meeting.

An invitation to send a representative to the Symposium Management Trauma and Disaster Problems in Miami, Florida on November 10-11 was reviewed and it was determined no representative would be sent.

The notice of the AMA Conference on Sports to be held in Houston on November 26 was reviewed and it was agreed that those who could attend some of these sessions would do so.

There being no further business the committee adjourned to meet again at 6:00 p.m. on Sunday, October 8, 1967 at the Columbia Club.

THE COUNCIL

Sept. 17, 1967

The Council of the Indiana State Medical Association and their wives toured the headquarters of the American Medical Association on Saturday, September 16, 1967.

The Council was called to order in the Board Room of the AMA Building at 10:00 a.m., Sunday, September 17. Present were:

First District—P. J. V. Corcoran, G. M. Wilhelmus

Second District—Joe Dukes, Betty Dukes

Third District—Donald M. Kerr

Fourth District—Jack Shields

Fifth District—Wilbert McIntosh

Sixth District—Not represented

Seventh District—Albert M. Donato, John O. Butler

Eighth District—Donald R. Taylor, Paul Sparks

Ninth District—Peter R. Petrich

Tenth District—Lowell H. Steen, Herman Wing

Eleventh District—Lowell J. Hillis, James A. Harshman

Twelfth District—Milton F. Popp, William Clark

Thirteenth District—George B. Gattman

Officers:

Eugene S. Rifner, president

G. O. Larson, president-elect

Lester H. Hoyt, assistant treasurer

Jas. A. Waggener, executive secretary

Robert E. Robinson, legal counsel

Executive Committee:

Ralph V. Everly, chairman

Burton E. Kintner

Absent were:

Robert M. Reid

Elmer L. Wallace

A. W. Cavins

Frank Green

Clarence G. Kern

Otis R. Bowen

Guests:

F. J. L. Blasingame, M.D., executive vice-president of AMA

W. J. Brown, Indiana field representative of the AMA

Minutes of the Council meeting held July 30 were approved on motion of Drs. Popp and Petrich.

The chairman read a letter of resignation from Dr. Ottis N. Olvey, treasurer of the association, and informed the Council of the action taken by the Executive Committee. On motion by Dr. Kerr, seconded by many, the secretary was instructed to include the regrets of the Council along

with those of the Executive Committee when writing to Dr. Olvey.

Reports of Councilors

No report from the First and Second District. The Third District—Dr. Kerr reported a request of the remission of dues from Dr. Reagan for 1967. On motion of Dr. Kerr and Dr. Popp, the motion was carried. No report from the Fourth and Fifth Districts. Sixth District was not represented. Dr. Donato of the Seventh District introduced Dr. Butler, the alternate councilor. No report from the Eighth and Ninth Districts. Tenth District councilor reported the Tenth District would hold a meeting at Phil Smidt's on October 4th and all councilors were invited to attend this very important meeting. The councilor from the Eleventh District reported on their district meeting held on September 13th and announced their 1968 meeting would be held in Carroll County. The councilor from the Twelfth District reported on a special meeting held on August 30th concerning the question previously discussed by the Council on the suitability of Ft. Wayne for the 1968 meeting. On motion of Dr. Popp, seconded by Dr. Kerr, it was moved to reopen discussion on this question. The facilities were discussed by Drs. Corcoran, Larson, Donato and others. On motion of Dr. Shields, seconded by Dr. Kerr, the chairman was instructed to appoint a special committee to review the Ft. Wayne situation prior to the next meeting. There was no report from the Thirteenth District.

The president and president-elect both reported on their activities and the president expressed his appreciation for the helpfulness and cooperation of the Council during his year as president.

The report of the treasurer was approved on motion of Drs. Popp and Kerr.

The chairman of the Executive Committee, who is also chairman of the Building Committee, reported on the meeting held by his committee with representatives of the Building Committee of the Marion County Medical Society and on motion of Dr. Taylor, seconded by several, it was moved that this matter be taken from the authority of the Building Committee and returned to the Council.

The chairman of the Executive Committee then reported on the proposed Gaslight party and the arrangements which had been approved by the Executive Committee. The report was approved to concur and taken by consent.

The chairman of the Council reviewed the question of M.D. identification on driver's licenses as a means of additional iden-

tification in emergency and disaster situations. On motion of Drs. Larson and Shields, it was moved that the association should make every effort to reinstate this method of identification.

Resolutions proposed to be sent to the House of Delegates from the Council were then reviewed and the matter of establishing dates of district meetings was discussed at length. On motion by Drs. Petrich and Steen, it was established as a policy that the councilors, working with the district societies, attempt to establish recurring dates so as not to conflict with other districts and report this to the headquarters office.

Resolutions concerning the including of PAC dues on the dues statements, computerized billing, and support of the PAC movement were all approved for introduction by the Council to the House of Delegates.

The question of introducing a resolution calling for the creation of the office of Speaker of the House of Delegates on motion of Drs. Rifner and Shields, the Council rescinded the previous action on this matter.

A discussion was held on several federal programs and on motion of Dr. Shields, this was deferred until the October meeting of the Council.

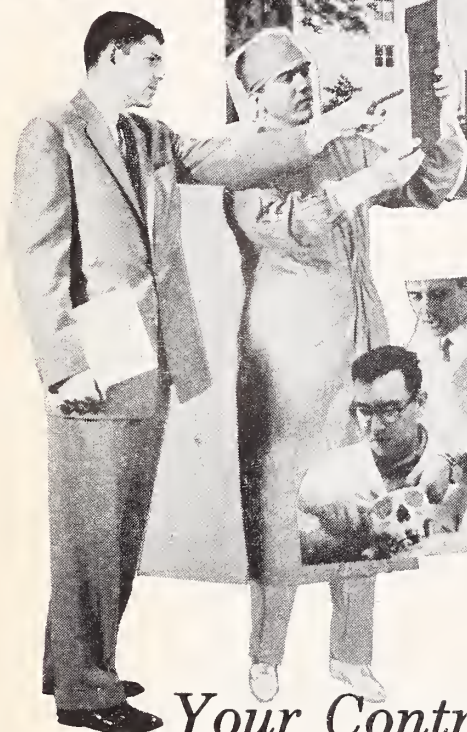
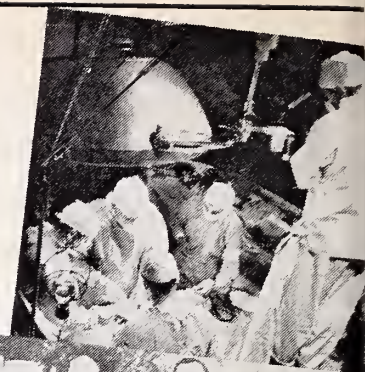
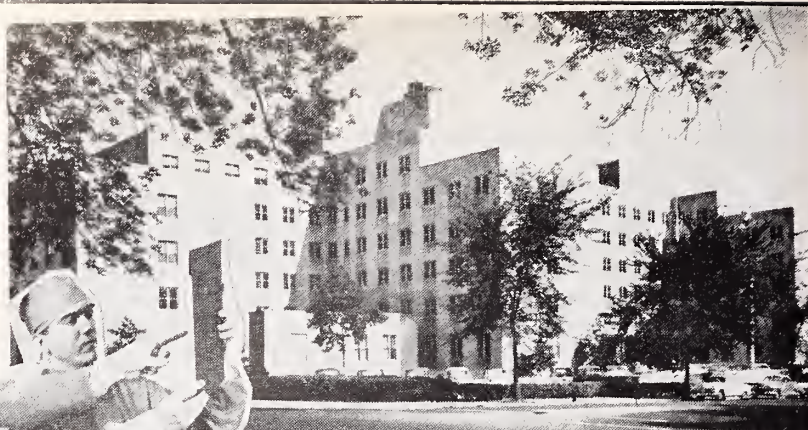
On motion of Drs. Popp and Larson, the Council is to introduce a motion calling for the opinion of members concerning the future plans for the association.

Dr. Shields then called to the attention of the Council the fact that the Indiana State Medical Association should submit more resolutions to the AMA House of Delegates and suggested a resolution on the subject of foreign physicians and one on hypnosis be prepared for this purpose. By consent it was agreed that the attorney and Dr. Shields would prepare such resolutions.

It was also agreed that the association should put in a resolution to the House of Delegates calling for the Commission on Legislation to introduce a bill in the 1969 session of the legislature to declare cultism a felony in the state of Indiana.

The members of the Council and their wives were served a luncheon by the AMA in the AMA headquarters building and reconvened following the luncheon to hear a talk by Dr. F. J. L. Blasingame concerning the activities of the American Medical Association.

There being no further business, the Council adjourned to meet again at 7:30 a.m. Monday, October 9th, in the Columbia Club, Indianapolis. ◀



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

COMMERCIAL ANNOUNCEMENTS

NEEDED: General practitioner and internist for cosmopolitan small Indiana resort town. Home of Culver Military Academy. Located on beautiful Lake Maxinkuckee. Salary \$18,000 up depending on experience leading to early association or partnership. Contact Joseph D. Howard, M.D., Culver, Ind. Phone 842-3568.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION, Queenstown, Maryland 21658.** Telephones: 301-827-7166 or 301-827-7160.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

INTERNIST: Position available for a Board Certified or qualified internist in a 200-bed modern, progressive general hospital with 104-bed medical service; fine opportunity in a city of 185,000 near Chicago and Detroit; liberal salary range dependent on qualifications; excellent fringe benefits; must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

PSYCHIATRIC RESIDENCIES: Accepting applications for January and July, 1968. Balanced didactic-clinical program providing extensive, varied experience with both inpatient and outpatient adults and children. Fully approved 3 year training. Three year plan: \$8,978; \$9,417; \$10,210. Five year career plan: \$10,231; \$11,797; \$13,739; \$17,497; \$18,458. Located in Michigan's serene, scenic water wonderland. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan, 49684. An equal opportunity employer.

POSITION AVAILABLE: For physician with some psychiatric training or experience to head a 24-bed intensive treatment psychiatric service; extensive training or experience not required; excellent opportunity to develop in the field of psychiatry in a city of 185,000 near Chicago and Detroit. Must be licensed to practice medicine or surgery in a state, territory or commonwealth of the United States, or in the District of Columbia. Non-discrimination in employment. Excellent fringe benefits. Liberal salary range dependent on qualifications. Contact Chief of Staff, Veterans Administration Hospital, Fort Wayne, Ind.

WANTED: G. P. for aggressive town of 1,300 in southern Indiana. New Sears-Roebuck medical clinic to be built in immediate future. Clinic available rent free first 90 days; reasonable rent thereafter or may purchase. Contact Gordon A. Triplett, Box 37, Osgood, Ind. 47037.

WANTED: Physician or physicians to operate emergency room at St. Francis Hospital. Four doctors needed for full-time coverage. Guaranteed minimum annual stipend. Contact committee members: Dr. A. L. Blake, Dr. Charles Dill or Dr. Robert Nagan, St. Francis Hospital, Beech Grove, Ind.

MODERN OFFICE SPACE AVAILABLE AT PRIME EASTSIDE LOCATIONS

• Community Medical Building

• Eleventh & Arlington Avenue

Newly decorated professional offices. Pharmacy at both locations. For information contact

JUSTUS COMPANY

357-8055

Mr. Ernst

HUNTERS: Roy Martin & Sons Hunting Preserve, Route 7, Box 243, Muncie, Ind., is now open for business. We have plenty of good flying quail, chukars and pheasants. Rates on release: quail, \$2.00; chukars, \$3.00; pheasants, \$3.50. Dogs and guides available. For further information, call 317-284-8939, Muncie, Ind.

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month
PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

November 1967

Volume 60

No. 1

Abbott Laboratories	1545-50	Mutual Medical Insurance, Inc.	159
American Tobacco Company	1479	National Drug Company, The	156
Burroughs Wellcome & Co., Inc.	1484	Parke, Davis & Company	2nd Cove
Campbell Soup Company	1529	Philips Roxane Laboratories	1502-03
Dairy Councils in Indiana	1583	Pitman-Moore Company	1542-43
Dorsey Laboratories	1481, 1573	Poythress, Wm. P. & Co., Inc.	1512, 1586-87, 159
Geigy Pharmaceuticals	1483, 1506-09, 1532-33, 1588-89	Robins, A. H. Company, Inc.	1499-1500, 1590
Hanger, J. E., Inc.	1591	Roche Laboratories	4th Cove
Harding Hospital	1603	Rorer, William H., Inc.	1501
Home Lawn Mineral Springs	1596	Sandoz Pharmaceuticals	1510-12
Hynson, Westcott & Dunning, Inc.	1475	Searle, G. D. & Co.	1530-31
Indiana Medical Bureau	1505	Stuart Company, The	1477
Lederle Laboratories	1521, 1555, 1579-80, 1605	Syntex Laboratories, Inc.	1485-91
Lilly, Eli & Company.....	1514, 1534-36, 1568-70, 1600-1601	Tutag, S. J. & Company	1594
Medical Protective Co. of Ft. Wayne	1602	Wabash Valley Hospital	1498
		White-Haines Optical Co.	1595
		Winthrop Laboratories	1495

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

The JOURNAL

OF THE INDIANA STATE
MEDICAL ASSOCIATION

Indianapolis,
Indiana

Vol. 60 • No. 12

December, 1967



J-0-P
Univ. of Calif.
Med. Ctr. Library
Acquisitions Dept.
San Francisco, Calif. 94122

12-67

U.C. MEDICAL CENTER LIBRARY

JAN 9 1968

San Francisco 94122

Dilantin® (diphenylhydantoin)

PARKE-DAVIS

In untold thousands of epileptic patients... Dilantin has been, and continues to be, the bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored.

ADVERSE REACTIONS: Allergic phenomena such as polyarthropathy, fever, skin eruptions, and acute generalized morbilliform eruptions with or without fever. Rarely, dermatitis goes on to exfoliation with hepatitis, and further dosage is contraindicated. Gingival hypertrophy, hirsutism, and excessive motor activity are occasionally encountered. During initial treatment, side effects may include gastric distress, nausea, weight loss, nervousness, sleeplessness, feeling of unsteadiness. Macrocytosis, megaloblastic anemia, leukopenia, granulocytopenia, thrombocytopenia, pancytopenia, agranulocytosis, and aplastic anemia have been reported. Nystagmus, lymphadenopathy, lupus erythematosus, erythema multiforme (Stevens-Johnson syndrome), and a syndrome resembling infectious mononucleosis with jaundice have occurred. DILANTIN is supplied in several forms including Kapseals® containing 0.1 Gm. and 0.03 Gm. diphenylhydantoin sodium.

Parke, Davis & Company, Detroit, Michigan 48232

The color combinations of the banded capsules are Parke-Davis trademarks. The orange-banded white capsule identifies Parke-Davis 0.1 Gm. diphenylhydantoin sodium; the pink-banded white capsule 0.03 Gm. diphenylhydantoin sodium.

PARKE-DAVIS

015R67



Lutrexin[®]

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

**IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF
PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION**

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting
uterine muscle of the guinea pig.)

Office of Publication

3935 N. Meridian, Indianapolis, Indiana 46208

Contents

SCIENTIFIC

Cardiac Pacemakers, William Storer, M.D., A. D. Dennison, Jr., M.D., Indianapolis	1647
An Addition to the Somatic Treatment of Alcoholism, J. R. Matthew, M.D., Westville	1650
Aneurysm of the Hepatic Artery: Report of a Case, Kenneth L. Schermer, M.D., Portsmouth, Va.	1652
Electrocardiogram of the Month: A-V Nodal (Junctional) Tachycardia in Emphysema, Charles Fisch, M.D., Indianapolis	1655
X-Ray Conference: Arteriographic Demonstration of Parathyroid Adenoma, Erich K. Lang, M.D., Indianapolis	1656
Fractures and Orthopedic Problems: The Recognition and Treatment of Dupuytren's Contracture, James B. Wray, M.D., Indianapolis	1658
The Cancer You View: Patrick A. Dolan, M.D., Indianapolis	1663

EDITORIALS

Measles Eradication	1664
"Not the Name by Which it is Sold"	1664
Thoughts on an Old Problem (Guest)	1665
Dr. E. S. Rifner, ISMA Ex-President (Guest)	1666
Mathematics Teachers and Others (Guest)	1666
Editorial Notes	1667

SPECIAL FEATURES

Meet The Journal Staff	1668
For Winter Fun and Fitness: Curling, Thomas N. Davis, III, M.D., Hammond	1680
Drug Stocks Ease	1684
American Cancer Society Forms Speakers Bureau	1687
Status of Measles Eradication in Indiana, A. L. Marshall, Jr., M.D., Indianapolis	1691

1967 CONVENTION

1967—The Convention Story	1725
President's Address, Eugene S. Rifner, M.D., Van Buren	1746
Address to the House of Delegates, C. O. Larson, M.D., LaPorte	1749
The Student American Medical Association, Barth A. Green, A.B., Indianapolis	1753
Convention Election Results: Dr. Patrick J. V. Corcoran is Named President-Elect	1755
The Winners	1756
Index to House of Delegates Proceedings	1757

REGULAR FEATURES

Month in Washington	1622
What's New?	1629
Fourth Estate	1630
From The Journal 50 Years Ago	1645
President's Page	1670
The Woman's Auxiliary Reports to ISMA	1675
Gleaned from the British Medical Journal, Jack W. Hickman, M.D., Indianapolis	1676
News from Indiana University School of Medicine	1686
Medicine At Law	1694
Physicians' Role in National Blue Shield (One of a Series)	1698
Abstracts, Book Reviews	1706
News Notes	1711
Wanted: Locations, Physicians	1715
Annual Meeting Dates of Professional Medical and Allied Organizations	1717
Board of Health Report	1720
Future Meetings, Seminars, Courses	1721
County, District News	1724

BUSINESS

Executive Committee:	
October 8, 1967	1776
October 12, 1967	1776
The Council:	
October 9, 1967	1777
October 10, 1967	1781
October 12, 1967	1782

EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

Representative for national advertising is the State Medical Journal Advertising Bureau, 510 N. Dearborn St., Chicago, Ill. Representative for Indiana advertising is Mr. L. D. Kingsbury, 339 Poplar Rd., Indianapolis.

Entered as second class matter January 25, 1933, at the Postoffice at Indianapolis, Indiana. Copyright, 1967 by the Indiana State Medical Association. Published monthly at 3935 N. Meridian, Indianapolis 46208.

Second-class postage paid at Indianapolis, Indiana and at additional mailing office.

About Our Cover
on page 1680.

ACID GAS

DUAL PROBLEM IN PEPTIC ULCER

Relief of hyperacidity is still a primary goal in the treatment of peptic ulcer. And antacids are the most widely used means of achieving this relief. But antacids alone cannot influence the distention and bloating which so often add to ulcer distress.

THIS IS WHY MYLANTA® PROVIDES:

the two most widely used antacids—magnesium and aluminum hydroxides—to help secure rapid acid neutralization with little chance of laxation or constipation;

PLUS

the defoaming action of simethicone—to help relieve the painful gas symptoms which often accompany peptic ulcer.

Mylanta®

antacid therapy plus an added benefit

nonfatiguing flavor/smooth pleasant texture; both assure patient cooperation during long-term therapy.



Division of / ATLAS CHEMICAL INDUSTRIES, INC. / Pasadena, Calif.

THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone 925-7545
ANNUAL CONVENTION—OCTOBER 14-17, 1968—FORT WAYNE

OFFICERS FOR 1967-68

President—G. O. Larson, M.D., 1110 Indiana Ave., LaPorte 46350.

President-Elect—Patrick J. V. Corcoran, 3700 Bellemeade, Evansville 47715.

Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis 46207.

Assistant Treasurer—Malcolm O. Scamahorn, Pittsboro 46167.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 46208.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 46208.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 46208.

Field Secretary—Mr. Robert J. Amick, Oak Hill, R.R.3, Scottsburg 47170.

Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian, Indianapolis 46208.

Legal Counselor—Mr. Robert Hollowell, 1440 Consolidated Bldg., Indianapolis 46204.

Editor, The JOURNAL—Frank B. Ramsey, M.D., 1802 N. Illinois St., Indianapolis 46202.

Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian, Indianapolis 46208.

COUNCILORS

District	Term Expires
1—Gilbert M. Wilhelmus, Evansville	Oct. 1968
2—Joe Dukes, Dugger	Oct. 1969
3—Donald M. Kerr, Bedford	Oct. 1970
4—Robert M. Reid, Columbus	Oct. 1968
5—Wilbert McIntosh, Riley	Oct. 1969
6—Stephen D. Smith, Knightstown	Oct. 1970
7—Albert M. Donato, Indianapolis	Oct. 1968
8—Donald R. Taylor, Muncie	Oct. 1969
9—Peter R. Petrich, Attica	Oct. 1970
10—Lowell H. Steen, Whiting (Chairman)	Oct. 1968
11—Lowell Hillis, Logansport	Oct. 1969
12—William R. Clark, Fort Wayne	Oct. 1970
13—Otis R. Bowen, Bremen	Oct. 1968

Section on Surgery:

Chairman—Donald M. Schlegel, Indianapolis
Vice-chairman—Henry Larzelere, Marion
Secretary—Austin Gardner, Indianapolis

Section on Internal Medicine:

Chairman—I. E. Michael, Indianapolis
Vice-chairman—Louis Sandock, South Bend
Secretary—Robert L. Rudesill, Indianapolis

Section on Ophthalmology and Otolaryngology:

Chairman—M. Richard Harding, Indianapolis
Vice-chairman—David E. Brown, Indianapolis
Secretary—George A. Clark, Indianapolis

Section on Anesthesiology:

Chairman—William M. Matthews, Indianapolis
Vice-chairman—Merle E. Pickett, Fort Wayne
Secretary—Jerry R. Miller, Indianapolis

Section on General Practice:

Chairman—Jay S. Reese, Martinsville
Vice-chairman—Robert Mouser, Indianapolis
Secretary—Richard Juergens, Fort Wayne

ALTERNATE COUNCILORS

District	Term Expires
1—.....
2—Betty Dukes, Dugger	1968
3—Elmer L. Wallace, New Albany	1968
4—Jack E. Shields, Brownstown	1967
5—Cleom M. Schauwecker, Greencastle	1970
6—Frank Green, Rushville	1969
7—John O. Butler, Indianapolis	1969
8—Paul Sparks, Winchester	1967
9—Clarence G. Kern, Lebanon	1968
10—Herman Wing, Gary	1969
11—James A. Harshman, Kokomo	1968
12—Frederic L. Schoen, Fort Wayne	1970
13—George B. Gattman, Elkhart	1967

SECTION OFFICERS 1967-68

Section on Obstetrics and Gynecology:

Chairman—Robert M. Reid, Columbus
Vice-chairman—Tom W. Wachob, Jr., Kokomo
Secretary—Charles R. Echt, Indianapolis

Section on Public Health and Preventive Medicine:

Chairman—Donald M. Kerr, Bedford
Vice-chairman—T. Neal Petry, Delphi
Secretary—Henry G. Nester, Indianapolis

Section on Radiology:

Chairman—Richard A. Silver, Indianapolis
Vice-chairman—John A. Robb, Indianapolis
Secretary—Edwin F. Koch, Jr., Muncie

Section on Nervous and Mental Diseases:

Chairman—Gordon T. Brown, Indianapolis
Vice-chairman—James E. Benson, Elkhart
Secretary—Wesley A. Kissel, Indianapolis

Section on Pathology:

Chairman—Robert J. Frost, Michigan City
Vice-chairman—
Secretary—Robert L. Costin, Indianapolis

Section on Pediatrics:

Chairman—Roland E. Miller, Lafayette
Vice-chairman—Gustaf W. Erickson, South Bend
Secretary—Morris Green, Indianapolis

DELEGATES TO THE AMA

Terms expire December 31, 1968:

Delegates	Alternates
Harold C. Ochsner Indianapolis	Don E. Wood Indianapolis
Eugene F. Senseny Fort Wayne	Robert M. Brown Marion
Frank H. Green Rushville	Kenneth O. Neumann Lafayette

Terms expire December 31, 1969:

Delegates	Alternates
Guy A. Owsley Hartford City	Maurice E. Glock Fort Wayne
Jack E. Shields Brownstown	Dwight W. Schuster Indianapolis

Before prescribing, see complete prescribing information in SK&F literature or PDR. A brief precautionary statement follows.

Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction.

Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.

Usage in Pregnancy: Use cautiously, especially in the first trimester. **Note:** The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.

Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible side effects of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported but no causal relationship has been established.

**a stuffy nose
is no
laughing matter**

Ornade® Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

Spansule® Capsules

brand of sustained release capsules

**each one can
give him all-day
or all-night relief**



Smith Kline & French Laboratories



ISMA Committees and Commissions for 1967-1968

COMMITTEES

Executive

Ralph V. Everly, Indianapolis, chairman; Burton E. Kintner, Elkhart; G. O. Larson, LaPorte, President; Patrick J. V. Corcoran, Evansville, President-Elect; Lowell H. Steen, Whiting, Chairman of the Council; Lester H. Hoyt, Indianapolis, Treasurer; Malcolm O. Scamahorn, Pittsboro, Assistant Treasurer.

Grievance

Philip B. Reed, Indianapolis, chairman; Marvin L. McClain, Scottsburg, vice-chairman; Robert G. Young, Marion, secretary; Kenneth L. Olson, South Bend; Earl W. Mericle, Indianapolis; Guy A. Owsley, Hartford City; William R. Clark, Fort Wayne; Maurice E. Glock, Fort Wayne; Hugh B. McAdams, Lafayette; William R. Noe, Bedford.

Student Loan

Lester D. Bibler, Indianapolis, chairman; Glenn W. Irwin, Jr., Indianapolis, vice-chairman; Mr. Robert Hollowell, Indianapolis, secretary; James O. Richey, Indianapolis; Eugene S. Rifner, Van Buren; Ottis N. Olvey, Indianapolis; P. J. V. Corcoran, Evansville.

Medical-Legal Review

Lall G. Montgomery, Muncie; Truman E. Caylor, Bluffton; E. Rogers Smith, Indianapolis.

COMMISSIONS

Aging

Glen A. Ramsdell, Richmond, chairman; George M. Young, Gary, vice-chairman; Bernard B. Rosenblatt, Evansville, secretary; C. Philip Fox, Washington; Walter S. Fisher, Columbus; A. W. Cavins, Terre Haute; John O. Butler, Indianapolis; Ralph R. Ploughe, Elwood; Wallace R. Van Den Bosch, Lafayette; George W. Wagoner, Delphi; Nathan Salom, Fort Wayne; Donald T. Olson, South Bend; Andrew C. Offutt, Indianapolis; Wendell C. Anderson, Indianapolis; Ray Duncan, Bedford.

Constitution and Bylaws

George W. Willison, Evansville; Harry B. Parmenter, Jr., Vincennes; Thomas H. Goote, Jasper; Gordon S. Fessler, Rising Sun; M. C. Topping, Terre Haute; James F. Lewis, Liberty; Joseph F. Ferrara, Franklin; B. D. Wagoner, Union City; Chester L. Waits, Lafayette; O. L. Marks, East Chicago; Richard L. Glendening, Logansport; Maurice E. Glock, Fort Wayne; Edwin C. Mueller, LaPorte; William M. Sholty, Lafayette; Burton Kintner, Elkhart.

Convention Arrangements

Richard B. Hovda, Evansville, chairman; William M. Kendrick, Mooresville, vice-chairman; Boyd A. Burkhardt, Tipton, secretary; Clarence R. McIntire, Bloomington; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; John Mader, Richmond; Francis E. Stout, Muncie; John L. Ferry, Whiting; Durward W. Paris, Kokomo; Charles H. Aust, Fort Wayne; James D. Finrock, Elkhart; Kenneth Kahlstaedt, Indianapolis; Charles Fisch, Indianapolis.

Governmental Medical Services

Okla W. Sicks, Indianapolis, chairman; Jerome E. Holman, Jr., Indianapolis, secretary; William C. Fisher, Evansville; Charles Hendrix, Vincennes; Guy H. Waldo, Bedford; Herman Echsner, Columbus; Dick J. Steele, Greencastle; Tom S. Shields, Richmond; Robert P. Scott, Indianapolis; J. F. Hinchman, Parker; Ramon B. DuBois, Lafayette; Edward J. Dierolf, Gary; Ernest C. Murray, Kokomo; George D. Buckner, Fort Wayne; James E. Wenger, Nappanee.

Inter-Professional Relations

Pierre C. Talbert, Bluffton, chairman; Fred Flora, Frankfort, vice-chairman; Virgil E. Angel, Highland, secretary; A. Wayne Ratcliffe, Evansville; Robert H. Rang, Washington; Charles X. McCalla, Paoli; John W. Ripley, Seymour; Paul Humphrey, Terre Haute; Wm. S. Robertson, Spiceland; Willis W. Stogsdill, Indianapolis; Robert D. Williams, Anderson; H. H. Dunham, Wabash; Robert H. Denham, Jr., South Bend; A. Alan Fischer, Indianapolis; Robert G. Husted, Munster.

Legislation

Dwight W. Schuster, Indianapolis, chairman; Eugene F. Senseney, Fort Wayne, vice-chairman; Jack W. Hickman, Indianapolis, secretary; Daniel M. Hare, Evansville; Harold Manifold, Bloomington; Elmer L. Wallace, New Albany; Fred W. Dierdorf, Terre Haute; John Davis, Flat Rock; Guy A. Owsley, Hartford City; Daniel Ramker, Hammond; Lester Renbarger, Marion; Otis R. Bowen, Bremen; Don E. Wood, Indianapolis; Joe Black, Seymour; James M. Kirtley, Crawfordsville; Max Hoffman, Covington; Leslie M. Baker, Aurora.

Medical Economics and Insurance

Chester A. Stayton, Jr., Indianapolis, chairman; Thomas G. Hamilton, Columbia City, vice-chairman; W. R. Van Den Bosch, Lafayette, secretary; Charles M. Sinn, Evansville; Edward

J. Ploetner, Jasper; William A. Johnson, North Vernon; Thomas J. Conway, Terre Haute; John F. Ling, Richmond; James M. Leffel, Indianapolis; Charles E. Geckler, Muncie; R. James Bills, Gary; Richard Wagner, Huntington; Jack W. Hannah, Elkhart; William J. Miller, Lafayette.

Medical Education and Licensure

John Sterne, Evansville; Walter Vaughn, Vincennes; John M. Paris, New Albany; Richard A. Snapp, Columbus; James B. Johnson, Greencastle; Kenneth E. Sherer, Richmond; George T. Lukemeyer, Indianapolis; John L. Cullison, Muncie; Peter R. Petrich, Attica; Leo Radigan, Gary; Lowell J. Hillis, Logansport; Joel Salom, Fort Wayne; Jene R. Bennett, South Bend; Merritt O. Alcorn, Madison; Forrest R. LaFollette, Hammond; Glenn W. Irwin, Jr., Indianapolis, Ex-Officio.

Public Health

Thomas O. Middleton, Bloomington, chairman; T. Neal Petry, Delphi, vice-chairman; Berniece M. Williams, Fort Wayne, secretary; Arnold W. Brockmole, Evansville; Glen D. Ley, Bedford; R. M. Seibel, Nashville; Cleon M. Schauwecker, Greencastle; Wilson L. Dalton, Shelbyville; Henry G. Nester, Indianapolis; Stanley W. Burwell, Muncie; Theodore C. Person, Veedersburg; Gilbert Z. Given, East Chicago; John E. Schreiner, Bremen; Theodore J. Smith, Whiting; Bertram Roth, Indianapolis.

Public Information

L. Edward Gaul, Evansville; E. T. Edwards, Vincennes; Donald M. Kerr, Bedford; Charles A. Rau, Columbus; Wm. G. Bannon, Terre Haute; Robert D. Spindler, Shelbyville; Robert W. Harger, Indianapolis; Howard Faust, Anderson; Fred M. Blix, Ladoga; Thomas C. Chael, Munster; Fred C. Poehler, La Fontaine; Frederic L. Schoen, Fort Wayne; Louis F. Sandock, South Bend; William G. Moore, La Porte; Loren H. Martin, Indianapolis.

Special Activities

Marvin E. Priddy, Fort Wayne, chairman; Joseph E. Coleman, Evansville; Norbert M. Welch, Vincennes; Eli Goodman, Charlestown; Robert O. Zink, Madison; John E. Freed, Jr., Terre Haute; John Smith, Greenfield; Harold C. Ochsner, Indianapolis; Henry Bibler, Muncie; Clarence G. Kern, Lebanon; Adolph Walker, East Chicago; Robert M. Brown, Marion; James D. Kubley, Plymouth; K. G. Hill, New Castle; Wes Shannon, Crawfordsville.

Voluntary Health Agencies

Norman R. Booher, Indianapolis, chairman; James H. Gosman, Indianapolis, vice-chairman; Wendell Ayres, Marion, secretary; Albert Ritz, Evansville; Ed R. Cantwell, Vincennes; Harry R. Baxter, Seymour; William G. Bannon, Terre Haute; Wayne Endicott, Greenfield; William A. Karsell, Indianapolis; James S. Fitzpatrick, Portland; Albert E. Applegate, Frankfurt; John G. Kolettis, Gary; William F. Oren, South Bend; Richard Willard, Bluffton.

Future Planning Committee

Earl W. Mericle, Indianapolis, chairman; Maurice E. Glock, Fort Wayne; James S. Fitzpatrick, Portland; A. Wayne Ratcliffe, Evansville; Fred S. Carter, LaPorte; William B. Challman, Mount Vernon; James E. Wenger, Nappanee; Charles F. Gillespie, Indianapolis; Leslie M. Baker, Aurora, (Ex-Officio Members)—Eugene S. Rifner, Van Buren; G. O. Larson, La Porte; Lowell H. Steen, Whiting; Ralph V. Everly, Indianapolis; Frank B. Ramsey, Indianapolis.

1966-67 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	R. E. Weitzel, Princeton	James L. Habgaard, Evansville	
2.		J. S. Brawn, Carlisle	
3.	Daniel H. Cannon, New Albany	Elmer L. Wallace, New Albany	
4.	Frank B. Bard, Crathersville	Harald E. Miller, Seymour	
5.	Thomas J. Canway, Terre Haute	Arnald W. Kunkler, Terre Haute	
6.	Paul Inlaw, Shelbyville	Perry Seal, Braakville	
7.	Jay Reese, Martinsville	James H. Gassman, Indianapolis	
8.	Danald E. Spahr, Portland	Joseph F. Varmahr, Portland	
9.	Nalan Hibner, Manticella	Max Fields, Manticella	May 16, 1968, Manticella
10.	Jahn J. Reed, Habart	Raymand Daherty, Crown Point	
11.	Charles Wise, Camden	Fred Paehler, La Fontaine	
12.	Max M. Gitlin, Blufftan	Berniece Williams, Fort Wayne	May 15, 1968, Angola
13.	E. C. Mueller, LaPorte	Jahn Hildebrand, South Bend	

If hypothyroidism leaves your patient feeling like this...

consider

LETTER[®]

(SODIUM LEVOTHYROXINE,
ARMOUR) TABLETS

Synthetic Thyroid Replacement Therapy



Letter[®] provides all the advantages of the synthetically pure chemical sodium levothyroxine. Dosage is precise and potency is consistently uniform.

and

Letter[®] is micronized to provide maximum opportunity for full absorption and clinical response.

In addition Letter[®] is distinctively color coded with an identifying number stamped on each tablet to provide accurate dosage control.

Indications: Hypothyroid conditions. **Contraindications:** Thyrotoxicosis, acute myocardial infarctions unless associated with hypothyroidism. In hypothyroidism with hypoadrenalism coadministration of corticoids with LETTER[®] is recommended. **Precautions and Side Effects:** Excessive dosage may result in diarrhea, cramps, palpitation, nervousness, rapid pulse, sweating. If symptoms appear, discontinue medication for several days, then reinstitute at a lower level. Since myxedema patients with heart disease may suffer seriously from abrupt increases in dosage, caution should be exercised in adjusting dosage. **Dosage:** Generally, the initial adult dosage is 0.1 mg. daily. This may be increased in small increments every one to three weeks until proper metabolic balance is achieved. **Available:** Bottles of 100 tablets, in six potencies: 0.025 mg. (violet), 0.05 mg. (peach), 0.1 mg. (pink), 0.2 mg. (green), 0.3 mg. (yellow), and 0.5 mg. (white).



ARMOUR PHARMACEUTICAL COMPANY • CHICAGO, ILLINOIS

COUNTY MEDICAL SOCIETY DIRECTORY

COUNTY

Adams
Allen (Fort Wayne)

Bartholomew-Brown
Benton
Boone
Carroll
Cass

Clark
Clay
Clinton

Daviess-Martlin
Dearborn-Ohio
Decatur
DeKalb
Delaware-Blackford
Dubois
Elkhart
Fayette-Franklin
Floyd
Fountain-Warren
Fulton
Gibson
Grant
Greene
Hamilton
Hancock
Harrison-Crawford
Hendricks
Henry
Howard
Huntington
Jackson-Jennings
Jasper
Jay
Jefferson-Switzerland
Johnson

Knox

Kosciusko
LaGrange
Lake

LaPorte

Lawrence

Madison
Marion

Marshall
Miami
Montgomery
Morgan
Newton
Noble
Orange
Owen-Monroe

Parke-Vermillion
Perry
Pike
Porter

Posey
Pulaski
Putnam
Randolph
Ripley
Rush
St. Joseph

Scott
Shelby
Spencer
Starke
Steuben
Sullivan
Tippecanoe
Tipton
Vanderburgh

Vigo
Wabash
Warrick
Washington
Wayne-Union
Wells
White
Whitley

PRESIDENT

Norval S. Rich, Decatur
Alvin J. Haley, Fort Wayne

Forest D. Daugherty, Columbus
A. L. Coddens, Earl Park
James R. McAfee, Lebanon
Don J. Wagoner, Burlington
Russell A. Eckert, Logansport

Clemente Oca, Jeffersonville
I. Frank Maurer, Brazil
Fred W. Flora, Frankfort

A. G. Blazey, Washington
Amado S. A. Mauricio, Rising Sun
Robert P. Acher, Greensburg
John H. Hines, Auburn
John R. Stanley, Muncie
Francis H. Gootee, Jasper
T. D. Arlook, Elkhart
Perry Seal, Brookville
James Y. McCullough, New Albany
Lowell R. Stephens, Covington
Howard R. Rowe, Rochester
William E. Dye, Oakland City
Richard E. Lahr, Marion
Robert Moses, Worthington
Paul Waitt, Sheridan
Wilbur Beeson, Greenfield
W. J. Brockman, Corydon
Eli Coats, Indianapolis
John E. Fisher, New Castle
Donald Fields, Kokomo
Barth E. Wheeler, Huntington
Kenneth E. Bobb, Seymour
Paul A. Williams, Rensselaer
Joseph F. Vormohr, Portland
Marcella Modisett, Madison
George Brown, Greenwood

Boyd K. Black, Vincennes

Robert D. Dormire, Warsaw
Lloyd R. Studebaker, LaGrange
David B. Templin, Lowell

P. J. Pilecki, Michigan City

John Reuter, Bedford

Robert D. Williams, Anderson
Dwight W. Schuster, Indianapolis

John K. Guild, Plymouth
Parker W. Snyder, Peru
V. G. Viray, Crawfordsville
Ellery T. Drake, Martinsville
John Parker, Goodland
Robert C. Stone, Ligonier
Marion L. Hagan, French Lick Springs
William C. Link, Bloomington

John Somerville, Clinton
Robert Gilbert, Tell City
M. H. Omstead, Petersburg
Charles Griffin, Valparaiso

Paul Boren, Poseyville
Henry R. Eshelman, Monterey
John Ellett, Jr., Coatesville
Howard W. Koch, Winchester
Bill E. Freeland, Batesville
Stephen Smith, Knightstown
S. E. Bechtold, South Bend

Carl R. Bogardus, Austin
Joseph Moheban, Shelbyville
John C. Glackman, Jr., Rockport
Guy B. Ingwell, Knox
Robert F. Barton, Angola
M. H. Bedwell, Sullivan
Phillip Rothrock, Lafayette
Robert L. Haller, Kempton
Eugene W. Austin, Evansville

William G. Bannon, Terre Haute
H. H. Dunham, Wabash
Peter B. Hoover, Boonville
A. R. Episcopo, Salem
Francis B. Warrick, Richmond
David C. Pietz, Bluffton
Nolan A. Hibner, Monticello
John Wilson, Columbia City

SECRETARY

Martin J. Graber, 265 W. Water St., Berne
James E. Shaw, 3610 Brooklyn Ave., Fort Wayne
Mr. Larry L. Pickering, Exec. Secy., 212 Med. Ctr. Bldg., Fort Wayne
C. David Ryan, 2600 Sandcrest Blvd., Columbus
D. L. McKinney, Box 398, Otterbein
Katherine A. Jackson, 95 E. Oak St., Zionsville
Robert Seese, 101 W. North St., Delphi
Edward L. TerBush, 216 Ninth Street, Logansport
Robert Witt, 201 E. Market St., Jeffersonville
Forrest R. Buell, 314 Lankford St., Clay City
George K. Hammersley, 361 E. Clinton St., Frankfort
Hamlin B. Lindsay, 511 E. Main St., Washington
Leslie M. Baker, 501 Fourth St., Aurora
James C. Miller, 207 N. Franklin St., Greensburg
Ben R. Graber, Waterloo
Jack M. Walker, 412 White River Blvd., Muncie
Herbert Erhart, 521 Fourth St., Huntingburg
Page E. Spray, 320 W. High St., Elkhart
J. L. Steinem, 818 Grand Ave., Connersville
Daniel H. Cannon, 1201 E. Spring St., New Albany
Jack D. Furr, Kingman
Wayne L. Knochel, 819 E. Ninth St., Rochester
Roland E. Weitzel, Princeton
Robert G. Young, 1207 Northwood Ct., Marion
Harry Rotman, Jasonville
H. R. Blackburn, Riverview Hospital, Noblesville
Bob R. Cagle, Box 155, New Palestine
David J. Dukes, 439 E. Chestnut St., Corydon
Carl J. Heinlein, 637 E. Main, Danville
Phyllis Grant, 3007 S. 14th St., New Castle
Jack Higgins, 400 S. Berkley, Kokomo
Carl S. Ray, Warren
William F. Blaisdell, 207 N. Pine, Seymour
K. R. Ockermann, 119 W. Harrison, Rensselaer
J. S. Fitzpatrick, 603 W. Arch St., Portland
Ott B. McAtee, Madison State Hospital, Madison
Merrill M. Wesemann, 251 E. Jefferson St., Franklin
John S. Murray, 317 Security Bank Bldg., Vincennes
Roland Snider, 604 E. Winona Ave., Warsaw
D. L. Mattox, Box 98, Howe
Reginald R. Barton, 7737 Forrest Ave., Gary
Mr. John B. Twyman, Ex. Dir., 4640 W. 5th Ave., Gary
Charles K. Liddell, 508 Pine St., Michigan City
Mrs. Polly Dent, Exec. Dir., 903 Indiana Ave., LaPorte
Reid C. Crosby, 2900 W. 16th St., P.O. Box 286, Bedford
William M. Stinson, 333 Jackson St., Anderson
John O. Butler, 234 E. Southern Ave., Indianapolis
Mr. Arthur G. Loftin, Exec. Secy., 2902 N. Meridian, Indianapolis
M. George Rosero, 921 Lake Shore Dr., Culver
Gordon S. Crates, Denver
W. E. Shannon, 408 W. Market St., Crawfordsville
Maurice A. Turner, 101½ N. Main St., Martinsville
Arthur Schoonveld, Brook
Joseph Greenlee, Avilla
Philip T. Hodgins, Orleans
Kermit Q. Hibner, 117 N. Grant St., Bloomington
Milton Herzberg, Clinton
Robert A. Ward, 507 Main, Tell City
M. H. Omstead, Petersburg
F. M. Sturdevant, Porter Memorial Hospital, Valparaiso
Herman Hirsch, 130 W. 5th St., Mt. Vernon
E. L. Hollenberg, 613 Tippecanoe Dr., Winamac
Anne S. Nichols, 707 E. Seminary, Greencastle
Paul W. Sparks, 214 S. Main St., Winchester
William J. Warn, Milan
Charles E. Sheets, Manilla
L. F. Sandock, 503 Sherland Bldg., South Bend
Mr. Harry Davis, Exec. Secy., 106 W. Monroe, South Bend
Ignacio B. Castro, 685 Wanda St., Scottsburg
P. M. Inlow, 103 W. Washington, Shelbyville
Michael O. Monar, Rockport
W. Allen Palmer, Knox
Wayne Schrepferman, Hamilton
J. S. Brown, Carlisle
Lindley Wagner, 2424 Ferry St., Lafayette
Albert E. Stouder, Kempton
Mr. Arthur P. Tiernan, Exec. Secy., 109½ S. E. 3rd., Evansville
Robert L. Meissel, 920 N. 19th St., Terre Haute
Stanley M. Zydlo, 1025 Manchester, Wabash
Robert C. Colvin, Newburgh
Roy L. Fultz, 304 E. Market St., Salem
Joseph Zore, 1308 N. "A" St., Richmond
Donald W. Meier, 303 S. Main St., Bluffton
Max L. Fields, Western Heights, Monticello
Jerome H. Wait, 115 S. Main St., Columbia City



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin *plus* belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea

problem. Available on your prescription or recommendation.

For acute, non-specific diarrheas
Donnagel® -PG (Donnagel with paregoric equivalent).

Donnagel formula plus powdered opium, USP, 24.0 mg. (equivalent to paregoric 6 ml.) (warning: may be habit forming). Alcohol, 5%.

All the antidiarrheal benefits of paregoric without the unpleasant taste. Real banana flavor makes it acceptable, even to children. See product literature before prescribing.

A. H. Robins Company
Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT! ROBITUSSIN®



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All the Robitussins contain glyceryl guaiacolate, the outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheo-bronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
 Each 5 cc. contains:
 Glyceryl guaiacolate 100 mg.
 Alcohol, 3.5%

For unproductive allergic coughs
ROBITUSSIN® A-C
 Each 5 cc. contains:
 Glyceryl guaiacolate 100 mg.
 Pheniramine maleate 7.5 mg.
 Codeine phosphate 10.0 mg.
 (warning: may be habit forming)
 Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control
ROBITUSSIN®-DM
 Each 5 cc. contains:
 Glyceryl guaiacolate 100 mg.
 Dextromethorphan hydrobromide . 15.0 mg.
 Alcohol, 1.4%

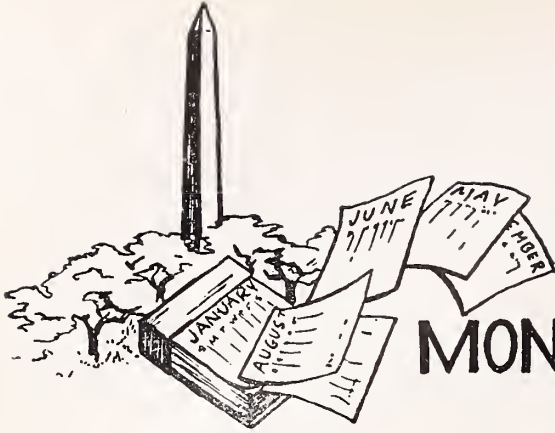
New! Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN®-PE
 Each 5 cc. contains:
 Glyceryl guaiacolate 100 mg.
 Phenylephrine hydrochloride . . . 10.0 mg.
 Alcohol, 1.4%

	ROBITUSSIN	ROBITUSSIN A-C	ROBITUSSIN-DM	ROBITUSSIN-PE
EXPECTORANT	●	●	●	●
DEMULCENT	●	●	●	●
COUGH SUPPRESSANT		●	●	
ANTIHISTAMINE		●		
LONG-ACTING (6-8 HOURS)			●	
NASAL, SINUS DECONGESTANT				●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A-H-ROBINS



This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

MONTH IN WASHINGTON

WASHINGTON, D.C.—A group of advisors to the Public Health Service and an AMA official separately emphasized the seriousness of the health manpower problem.

THE ALLIED Health Professions Education Subcommittee of the National Advisory Health Council said in a report to the PHS surgeon general, Dr. William H. Stewart, that health manpower is the critical factor in the provision of health services in this nation.

"WITH the rising capacity of medicine to provide a satisfying array of services, the lowering of financial barriers to service, and the growing acceptance of a public responsibility to assure that all people have adequate medical service, needs and demands for medical care continue to outstrip their availability," the report said.

"MANY PEOPLE are struggling with approaches to the measurement of health manpower shortages. But no one figure can express the total need. And even if it were possible to envision ideal health services staffing for a community, a state, or a nation, the continuing development of new knowledge and techniques, new patterns of service, and new methods of payment are constantly changing the needs, both for numbers and varieties of health workers."

DR. ALVIN J. INGRAM of Memphis, Tenn., a member of the AMA Board of Trustees, told the AMA Conference on Aging and Long-term Care in Baltimore, Md., that there is an urgent need for all categories of health personnel.

"WE HAVE BEEN challenged by government to revamp our system of health care, to make it available to everyone and to do so more economically than at present," Dr. Ingram said. "To do this will require not only larger numbers of health personnel, but more coordinated and efficient use of all members of the health team."

"THE BASIC PURPOSE of all medicine—research, education and practice—is the application of the art and science of the profession to the individual patient or to the community as a whole.

"FURTHERMORE, we are constantly exposed to remarks about the brain drain, the siphoning of physicians trained in other countries and their acceptance here to fill our own voids, even at the expense of intensifying already desperate shortages in other nations.

"YET WE HAVE our brain drain in this country—the consistent and progressive decrease in the ranks of practicing physicians as members of the profession turn from the primary responsibility of patient care to research, teaching and administrative service. In the past 15 years, the number of physicians in full-time private practice has decreased at the rate of almost one percent a year, from 75% in 1950 to 62% in 1965."

DR. INGRAM decried the growing dependence of the nation's health care system on foreign physicians.

"THIS DILEMMA can hardly be exaggerated," Dr. Ingram said. "Not one foreign graduate meets our domestic requirements which include graduation from an approved medical school which has undergone regular, competent inspection."

DR. INGRAM cited government figures showing that the percentage of foreign physicians in the United States had risen from 16% in 1956 to 26% in 1966 and that nearly half of them were from underdeveloped or developing countries that badly need their services at home.

PHS, NIH CHARGED WITH INEFFICIENT HANDLING OF GRANTS

THE HOUSE COMMITTEE on Government Operations has issued its third report charging costly and inefficient administration of research grant programs by the National Institutes of Health and other Public Health Service bureaus.

THE CONGRESSIONAL watchdog panel said the PHS had made relatively little effort to improve its administration of grants since the committee's two previous reports in 1961 and 1962.

"INADEQUATE administrative performance is demonstrated, for example, by the inept handling of payments for the indirect research costs of grantees and the extremely poor administration of the General Research Support and Health Sciences Advancement Award programs," the recent report said.

"NIH AND OTHER PHS bureaus were found to have made excessive indirect cost payments to grantees." (About \$500,000 in one case).

THE American Medical Association supported legislation to continue federal aid for construction, training and research under the Health, Education and Welfare Department's retardation program, but opposes grants to help pay for initial staffing.

THE AMA POSITION was outlined by Dr. F. J. L. Blasingame, AMA executive vice president, in a letter to the House Public Health and Welfare Subcommittee. He said:

"THE EXTENT to which the problem of mental retardation can be ameliorated in future years depends largely upon continued research. Although some breakthroughs have been effected such as the prevention of some types of mental retardation as a result of our increased knowledge of body metabolism, there are still gaps in research, personnel and financing which must be overcome. While the ultimate answer to the problem on mental retardation is prevention, we recognize that in the meantime, mentally retarded individuals must be cared for and must be educated and trained to the limit of their capabilities.

Continued



Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery

for these lesions has frequently been required and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant patients, since the drug may cross the placental barrier and adverse reactions which may occur in the adult (thrombocytopenia, hyperbilirubinemia, altered carbohydrate metabolism, etc.) are potential

problems in the newborn.

Precautions: Antihypertensive therapy with Hygroton should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents or other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Barbiturates, narcotics or alcohol may potentiate hypotension. Because of the possibility of progression of renal damage, peri-

odic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, Hygroton should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or

**For the
cardiac patient
on 2 pillows
a night,
consider one
Hygroton a day.**

**Hygroton®
chlorthalidone**

**new 50 mg. tablet
or 100 mg. tablet**

She was the picture of arteriosclerotic heart disease in failure.

She couldn't sleep a wink without an extra pillow.

Then her doctor prescribed digitalis and Hygroton.

First, her cardiac output improved. Then her breathing improved — along with her urinary output.

Nights could be a lot more pleasant for patients like this in your practice. Try it and see.

Hygroton therapy may also mean troublesome side effects for certain patients.

A summary of essential prescribing information is shown below.

severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, hyperuricemia, headache, muscle cramps, orthostatic hypotension, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urti-

caria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets

of 50 mg., in bottles of 100 and 1000. (B)R46-230-D

For full details, please see the complete prescribing information.



Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502
HY-5405S

"IN THIS REGARD, the AMA supports efforts to provide higher standards of care for the institutionalized retarded, special educational programs, day-care centers within the community, counseling services for the parents of retarded children, and efforts to create job opportunities for retarded adults. For these programs to be effective, the nation needs additional facilities and an increase in properly qualified personnel. We, therefore, are pleased to submit for the record our continued support of the expansion extension and improvement of facilities and services through construction, training and research grants

"THE BILL, however, also amends the present Act to authorize grants for meeting a portion of the cost of compensating professional and technical personnel during the initial operation of the facility. Although such federal financial assistance during the early years might enable a mental retardation facility to undertake a more comprehensive program than it might otherwise attempt, it can be demonstrated that once reliance is placed on a federal subsidy for staffing, the role of the federal government as a provider of operating funds will not easily be ended. Once a facility has been constructed, the community can and should assume the responsibility for its operation, including the costs of staffing."

PESTICIDE RESIDUE IN FOODS REMAINS LOW

PESTICIDE RESIDUES in the nation's food supply have remained low for the third consecutive year, according to the Food and Drug Administration's third annual "total diet" study. In the survey, food samples were collected in 30 cities over an 11-month period ending last April. Samples were analyzed to identify and determine the level of pesticide residues. The FDA said residues remained well below acceptable daily intake levels established by the World Health Organization and the Food and Agricultural Organization of the United Nations.

PRESIDENT APPOINTS ANOTHER COMMISSION

PRESIDENT JOHNSON appointed a National Advisory Commission to make recommendations on health facilities needed by the United States in the future. The chairman is Boisfeuillet Jones of Atlanta, Ga., president of the Emily and Earnest Woodruff Foundation and a former special assistant for health and medical affairs for the Department of Health, Education and Welfare.

NEW ACT AND ITS BENEFITS

THE RECENTLY-ENACTED Vocational Rehabilitation Act of 1967 creates a National Center for Deaf, Blind Youth and Adults, sets up a special system to grant federal aid, through state rehabilitation agencies for handicapped migrant workers, continues the federal-state financing system of state rehabilitation agencies for another two years, extends for another year federal planning grants to states studying the needs of the disabled, and eliminates state residency requirements for proving residency before aid can be received.

Coming home is wonderful

when you have Blue Cross-Blue Shield

After a long hospital stay, coming home is wonderful—if you have let Blue Cross-Blue Shield do the worrying for you about health care bills.

Blue Cross—Blue Shield provides generous benefits at the hospital, makes realistic allowances to your doctor.

And in these days of excellent, but expensive, health care, that's more important than ever.

Employers prefer Blue Cross-Blue Shield, too. They have no admission or claims forms to worry about—they're not running a branch office for some health insurer. All paper-work is handled directly between Blue

Cross-Blue Shield and hospital and doctor.

Yes, coming home is wonderful when you have Blue Cross-Blue Shield.

For you, because it was a worry-free homecoming—for your employer because your claim was processed so efficiently he probably didn't even know about it.

That's why people say—from the heart—"I don't know what we would have done without Blue Cross-Blue Shield."



Blue Cross-Blue Shield

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS, INDIANA 46204



(One of a series of ads being run in key Hoosier newspapers)

**Pick one to die.
Pick one for jail.
Pick one to waste away.
Pick three for happiness.**



Some children find happiness easily. Others need the help and guidance only a trained person can provide, medical attention they cannot afford, love they have been denied. When you decide to give to your United Fund or Community Chest, you may change a life.

Your fair share gift works many wonders/THE UNITED WAY



What's New?

"Planning the Community Hospital" by Roy Hudenburg and published by McGraw-Hill is a 429-page book devoted to a comprehensive and non-technical discussion of hospital planning from administrative and functional standpoints. Hudenburg has been concerned with hospital design in various ways since World War II. The book is divided into three parts. Part 1 deals with the nature of the hospital, describes it in terms of its personnel, travel within the hospital, and characteristics such as social pressures, and delves into the process of planning and construction. Part 2 treats the components of the hospital as parts of the six systems into which the author has divided hospital functions. The final part discusses social trends as they affect the provision of medical care in hospitals and economic factors in hospital operation.

* * *

Ames is introducing a new reagent strip—Azostix® Reagent Strips—a new colorimetric blood determination plastic strip. Azostix strips are transparent firmly constructed plastic, providing semi-quantitative estimates in 60 seconds for blood urea nitrogen (BUN) utilizing 10, 20, 30 and 50 mg./100 ml. color blocks. One drop of capillary or venous blood is all that is required from the patient for the determination.

* * *

Squibb announces another price reduction on their leading antibiotics—Mysteclin®-F and Pentids®. The reduction in wholesale prices varies in the several dosage forms for the two drugs from 10%, to as high as 34%, all effective on August 1.

* * *

A new Doubleday book "Hide-and-Seek" by Charles H. Knickerbocker, M.D., considers the imbalances created by the phenomenon of physicians who forget the emotions while treating physical diseases and vice-versa in the case of psychiatrists. Case histories are used to develop the theme. Dr. Knickerbocker is a practicing internist, who has five novels to his credit, prior to "Hide-and-Seek."

* * *

A new National Zip Code Directory is now available which lists over 35,000 U.S. Post Office Zip Codes. A handy 6 x 10" book for quick reference, it is suitable for both home and office use. Printed on quality paper with durable red, white and blue cover, it gives long and faithful service even under hard use conditions. Ideal for finding zip code numbers for all correspondence: letters, invitations, greeting cards, bills, etc. Helps speed up delivery of all mail. Only \$1.00 plus 25c for handling and postage. Order from Zip Code Publishing Co., Inc., 7426 W. Capitol Dr., Milwaukee, Wis. 53216.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments, and surgical appliances and book publishers. Each item is published as news and does not necessarily constitute an indorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.



I'm afraid you have some sort of a mental block.

Automobile Leasing

All Types Available

12 Months or Longer

If You Want To

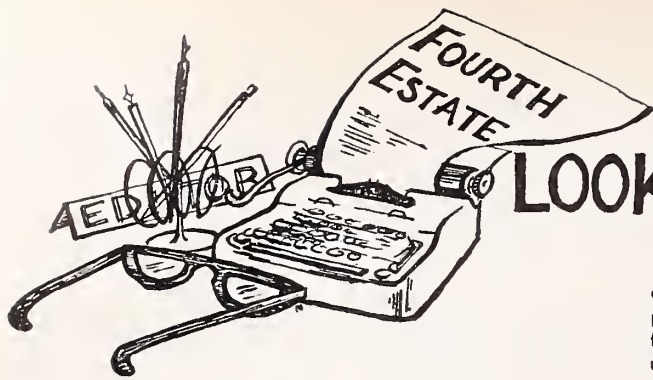
Know The Facts

CONSULT OUR SPECIALISTS

Phone 317-253-4415

Quality Leasing, Inc.

6310 GUILFORD AVE.
INDIANAPOLIS, IND.



LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Better Pilot Licensing

The American Medical Association has wisely called for better precautions against licensing of pilots with physical or mental health problems that might hinder their performance in the air. The Federal Aviation Agency would do well to act on the recommendations of the AMA's committee on aerospace medicine.

The AMA is concerned lest the federal agency certify persons without knowing all the pertinent facts about their health. This appears quite possible under the present system. As the medical group notes, the FAA may be unaware of problems "such as habitual alcoholism, severe emotional or mental states, epilepsy, temporary heart irregularities or use of tranquilizers, antihistamines, LSD or narcotics," even though these are known to the applicant's personal physician.

This argues the wisdom of the AMA's proposal that Federal Aviation Agency regulations be altered to require an applicant to furnish the names of all doctors who have examined or treated him, and to authorize the doctors to give the FAA any data pertinent to medical certification.

To clinch the point, the AMA said: "The physician is faced with the possibility that failure to reveal such information may carry responsibility for a disaster involving the deaths of his patient and of many other innocent people." With flying

rapidly on the increase, such precautions make excellent sense.—*Terre Haute Tribune*, Sept. 18, 1967.

Those Who Are Needed

There is something very special about a good doctor. In these days when so much emphasis is put on the common man and equality, the instinct of survival dictates that when we get sick, we want no part of the common man. We want an uncommonly good doctor, and good doctors are not created overnight. Moreover, it takes a person of certain aptitudes and qualifications to make a really good doctor.

To hear some of the talk about how to increase the physician population, one would think that all that is necessary is to open the doors of the medical schools and herd the young people in for training.

When it comes to the disciplines of science, the good doctor enjoys a happy combination of a penetrating scientific mind and a compassionate consideration for his fellowman—attributes beyond the average person. Expanding the doctor population cannot be accomplished as rapidly as laws can be passed that create demand for medical services.

The American Medical Association at its last annual meeting laid heavy stress on expanding medical school facilities and increasing the output of qualified medical practitioners. "...our resolve," states the Board of Trustees, "should always be as it is now; to use the best tested and most

forward looking measures to provide excellent health care for all of our citizens through an ample number of able, educated, and highly skilled physicians."

Gifted young persons of ability will find a life of work in the medical arts highly rewarding, spiritually and materially. Those who enter this field should dedicate themselves to maintaining the highest standards of the profession—*Shelbyville News*, Sept. 18, 1967.

Measles Not A Funny Business

Steps to eradicate the disease of measles have been taken here, and the program will be nationwide through the agencies of the various medical societies. Spearheading the drive in Floyd County is Dr. J. Y. McCullough, president of the medical society, and Dr. John P. Gentile, the city-county health commissioner.

It's time to stop thinking of measles as a slightly humorous childhood disease, says the American Medical Association.

Many people don't realize two important things about measles:

First, it's acripper and killer. Measles strikes millions of children, but the ones left with deafness or mental defects or encephalitis—or even the ones who die—seem to be forgotten by the public. Measles isn't at all a funny disease; it's one whose tragedy isn't fully realized.

Second, measles could be eliminated as a major health threat. Some medical officials believe it could be

eradicated in this country within a year. There's no doubt that it should be. Several types of anti-measles vaccine are available. They are easily administered by your physician and have been proven safe and effective.

Measles-susceptible children can be immunized by their family's physician. The best time is when they are approximately one year old. Older susceptible children—those who have neither had measles nor been given measles vaccine—should be immunized as soon as possible, particularly if they are of school age.

In many communities, and in the states of Rhode Island and Delaware, measles has been practically eliminated, by concerted, areawide immunization campaigns.

Such campaigns have been endorsed by the AMA's Council on Environmental and Public Health, the Indiana State Medical Association and the United States Public Health Service. Their organization requires the counsel and guidance of the local medical society and close cooperation by the community's civic, education and health organizations.

A Measles Eradication Sunday has been set here for October 15. The Floyd County Medical Society, supported by the Board of Health, the schools and civic groups, will offer free vaccination to all measles-susceptible children from one to 12 years of age.

The most important step is to ensure that your own children are protected from measles. If they have not been immunized, have it done on Measles Eradication Sunday — Oct. 15.—*New Albany Ledger-Tribune*, Oct. 1, 1967.

Friend To The Elderly

Many things can happen to elderly people who live alone. They can fall and break a fragile bone and lie helpless. They can be stricken with sudden illness and unable to reach the telephone.

The frequency of such mishaps

has aroused Community Hospital to take preventive steps. Starting Nov. 1, the hospital administration is starting a new program called "Telecare," for the benefit of elderly patients of physicians on the hospital staff.

Elderly patients will be asked to call the telecare number at Community Hospital each day. If the call does not come in, volunteers from the hospital auxiliary call the patient, and if no answer is received, the nearest neighbor, or a relative. If these calls do not get a response, calls go to the physician or to the police.

Community Hospital, by this move, has shown a heart-warming interest in the plight of lonely old people. It is probable the service will not be restricted to patients of the staff physicians but will be expanded to all old folks who need help.

This voluntary effort will do a great deal to meet a need that has been long apparent. It should bring additional peace of mind to the elderly who are forced by circumstances to live alone.—*The Indianapolis News*, Oct. 17, 1967.

Lessons Of History

Everyone is in favor of progress and a constant striving toward improvement—in short, a higher form of civilization. The trouble is that many of us, ignoring the lessons of history, have become followers of centralized government leadership in all important matters.

The new president of the American Medical Association, Dr. Milford O. Rouse, has expressed some fundamental thoughts on his profession and the American system. He says, "Capitalism, free enterprise, is a great deal more than just a system for seeking financial gain. It is a principle which holds that any citizen is entitled to a reward commensurate with his work. That entitlement, in exchange for effort, furnishes the stimulus that motivates the citizen to

do his very best in whatever he undertakes."

Dr. Rouse has also said that medicine has made outstanding progress in the United States "because practicing physicians, researchers, academicians — all members of the medical profession—have been free to follow their pursuits as they saw fit. They have not been forced to work for the state; for the glory of a party. Instead, they have been free to work for the patient, for the glory of God and for the furtherance of their professional skills."

Dr. Rouse has ably expressed the precepts of citizenship that have preserved liberty in the United States for nearly two centuries.—*Shelbyville News*, Sept. 30, 1967.

The Doctor Shortage

The happiness and the welfare of the people of a community depend upon many and diverse factors.

To mention only a few of them: stores, utilities, transportation and communication mediums, financial institutions, religious and cultural facilities, recreational places.

One aspect of the community life that year by year is looming larger in the public mind is adequate medical service. Hardly a community, large or small, urban or rural, today is amply supplied with physicians and surgeons. Richmond is no exception.

One survey by the Public Health Service shows a national need for at least 20,000 more physicians, and 10,000 additional interns and residents in hospitals and 10,000 to 15,000 more psychiatrists.

Liberty, 16 miles south of here, industrial and agricultural center for a large area, has only one full-time physician and two part-time physicians who also serve other nearby communities. It urgently seeks relief.

The residents of the Union County seat are so firmly determined to do something about the shortage of medical service in their community that they are studying plans for the

erection of a two-doctor medical building as one means of alleviating their plight.

The need for more doctors is apparent not only in rural areas and small communities but it also is a serious matter in the large centers of population.

New York State, according to the *U.S. News and World Report*, has 130 communities of 2,000 or more inhabitants that have no physicians. The same periodical says that "in Harlem (New York), with its hundreds of thousands there are only 12 private physicians practicing."

Some observers and students of the situation suggest that it is eminently a local problem in which every community should bestir itself to provide hospitable environment that will encourage physicians to remain and young men to enter the profession.

Communities may spend hundreds of thousands of dollars to entice new industries and they may prate long and hard about many municipal advantages, but what will it avail them if their communities lack medical service for their population.

Commerce and industry shun areas that have an unhealthy climate and a high death rate, but they also avoid cities lacking enough doctors to provide necessary medical service.

Wide-awake and progressive communities will strive to develop a civic life, conducive to a highly qualified medical profession.

The people of Liberty and Union County, our good neighbors to the south, are capitalizing on the idea. Figuratively and practically they are extending the right hand of fellowship, congeniality and neighborliness to physicians they want to live in their town.

Richmond also recognizes that the problem of obtaining more physicians and surgeons is an acute one.

Not long ago its residents met more than a quota of \$1.5 million, as part of a \$5 million program to improve and expand Reid Memorial Hospital.

Beginning Oct. 1, users of the facilities of Reid Memorial Hospital are paying higher room charges, an increase over last year of 45% for the best semiprivate rooms, 33% for the top private rooms and 63% for the best pediatric rooms. Hospital officials say these increases are needed to pay for better hospital service.

Shortage of physicians throughout the nation pits one community against another in the struggle for more local medical service. Laymen everywhere are limited in their capacity to help, but locally they are meeting the challenge through increased financial support of the hospital.

The lay citizen has every right to hope and to expect that the hospital administration and local medical profession are assuming their responsibility for providing an atmosphere among the medical associates that will help to keep and to attract qualified physicians.—*Richmond Palladium-Item*, Aug. 8, 1967.

Merited Awards

The diligence and high quality of the work done by two members of *The News* staff have received well-deserved recognition.

Les Koelling, whose name is familiar to all readers of *The News* sports pages, has been elected to the Indianapolis Hall of Fame by the Greater Indianapolis Bowling Association.

Business editor Robert Corya has received an award from the Indiana State Medical Association for excellence in writing.

Few if any men in this area have done as much to promote and increase the popularity of the great sport of bowling as Koelling. His widely read column, "Bowling With Koelling," has kept bowling fans well-informed for 37 years. In the early days of his column, he drove after working hours to all the bowling lanes in the city to collect scores. In 1935 he was a member of the city championship team.

Koelling is also widely recognized as one of the city's leading baseball authorities. In bowling or baseball, the fans have learned to have complete reliance on his knowledge and accuracy.

Bob Corya, who as business editor writes knowledgeably on a wide variety of subjects, authored a series on how management and labor have recognized the need for care of the mentally ill in company health clinics. The excellence of his work was recognized by a panel of 15 physicians and a committee of the Marion County Medical Society who chose him for the state association's award.

Associates of Koelling and Corya here at *The News* know that the honors could not have come to more deserving recipients.—*The Indianapolis News*, Oct. 13, 1967.

Family Doctor — New Specialist?

Remember the "good old family doctor"? You're showing your age if you do, for there aren't many left.

One who remembers, and laments, is a doctor himself. The general practitioner, writes Leon H. Dembo, M.D., in *Cleveland Physician*, the bulletin of the Cleveland Academy of Medicine, is rapidly becoming the forgotten man of medicine.

The GP was the kind, sympathetic, conscientious medic who sat at a patient's bedside, asked a few questions, used his eyes, ears, hands and brain, and invariably came up with a correct diagnosis, idealizes Dembo.

His treatment was simple but effective. He knew nothing of pretense or synthetic bedside manner. He made house calls any time of the day or night and never was too busy to have a short chat with the family. He was, in brief, a doctor, friend, father-confessor and adviser.

He didn't need a dozen laboratory tests to make a diagnosis, and when he sent a patient to the hospital, "you can bet your Aunt Nellie's pajamas that the patient was seriously ill." In those days, when the spec-

ialist was called in, the patient most likely had one foot inside the Pearly Gates.

Years ago, a doctor had 23 to 30 years of general practice behind him before he became a specialist, says Dembo. Today, medical graduates take a year of internship, one or two years of residency in some special field and emerge as specialists.

"Young Doctor X, during his residency at a university hospital, engages in a research project (with a grant of \$100,000 or more) on the home life of the kidney glomeruli.

"Cognizant of the 'publish-or-perish' edict, he also writes papers — important papers — such as: 'The Rate of Heat Radiation in Pregnant Chipmunks' or 'The Basal Metabolism of Honda Riders.' These are published in journals specializing in 40-page bombastic articles which are

highly successful in befuddling the readers and adding to the sum total of medical confusion."

Now medicine is deep in specialists. We have obstetricians, gynecologists, internists, laryngologists, otologists, proctologists, allergists, ophthalmologists, psychiatrists, neurosurgeons, etc.

Even the specialties are split into sub-groups, so that we have pediatric allergists, pediatric neurologists, cardiac surgeons, vascular surgeons, etc., etc.

We're not far from the point, thinks Dembo, when there will be "dextral" eye specialists who treat only diseases of the right eye and "sinistral" ophthalmologists who take care of left eyes. Or orthopedists who specialize in fractures of the arms, others who limit themselves to fractures of the legs.

The doctor exaggerates, of course, to make a point. No one would want to give up the medical advances of the past 50 years in exchange for a return of the "good old family doctor," no matter how kind, sympathetic and willing to be put-upon he was.

What will happen to the family doctor? ask Dembo. Either he'll become as extinct as the dodo bird or remain in business as a cartoon in a recent medical publication suggested.

It showed a specialist at the bedside of a patient. The caption read: "I and my other consultants would like your permission to call in a general practitioner."

Who knows? — general practice may be the coming specialty.—*New Albany Tribune*, Oct. 13, 1967. ◀

Current Concepts in Cardiology

An intensive program on "Current Concepts in Cardiology" is being offered by the Institute for Cardiovascular Diseases at Good Samaritan Hospital, Phoenix, Arizona and the American College of Cardiology. This meeting will be held at Del Webb's Towne House, Phoenix, Arizona on January 10, 11 and 12, 1968.

Program Director is Alberto Benchimol, M.D. with guest faculty: E. Grey Dimond, M.D., William Chardack, M.D., Darrell D. Fanestil, M.D., Mr. Dean Franklin, George C. Griffith, M.D., Paul G. Hugenholtz, M.D., Albert A. Kattus, Jr., M.D., C. Walton Lillehei, M.D., Oscar Magidson, M.D., Alfred Pick, M.D., Robert L. Van Citters, M.D.

This is an official program of the American College of Cardiology. The Institute of Cardiovascular Diseases Faculty consists of Alberto Benchimol, M.D., Lee Brown, M.D., Lee Ehrlich, M.D., and Marian Molthan, M.D. For information about this program write to William D. Nelligan, Executive Director, American College of Cardiology, 9650 Rockville Pike, Bethesda, Maryland 20014.



*"When I couldn't even smell corned beef and cabbage,
I decided it was time for you, Doc."*



Maybe he doesn't know when he's well off. But you might want to prescribe long-acting Novahistine LP anyway.

Two tablets in the morning and two in the evening will usually provide day and night relief by helping to clear congested air passages for normal, free breathing. Novahistine LP is formulated to provide continuous therapeutic effect for 8 to 12 hours. The decongestant ingredients help restore normal mucus secretion and ciliary activity—physiologic defenses against infection of the respiratory tract. Use cautiously in individuals with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Each Novahistine LP tablet contains phenylephrine hydrochloride, 25 mg., and chlorpheniramine maleate, 4 mg.

NOVAHISTINE® LP



PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis



The Arthritis Foundation salutes the thousands of dedicated physicians who volunteer their services in the nation's fight against crippling arthritis.

The Arthritis Foundation is the sole national voluntary health agency committed to conquering the rheumatic diseases. It provides the means for dynamic partnership between physicians and laymen to marshal leadership and resources toward the solution of this major national health problem.

The Arthritis Foundation looks forward to rapid growth with increasing opportunity for physicians to participate in the arthritis movement. For further information about The Arthritis Foundation and its programs write to the Foundation chapter in your community or to the Medical Department, Box 2525, New York, N.Y. 10001.

Floyd B. Odlum
Chairman of the Board

William S. Clark, M.D.
President

Donald F. Hill, M.D.
President of the American
Rheumatism Association Section

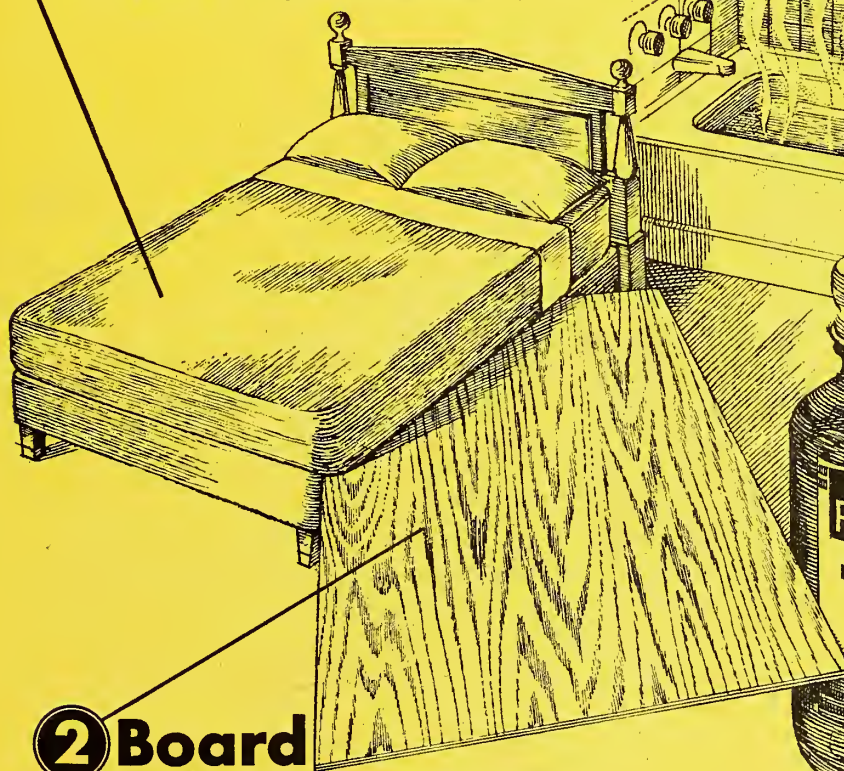
William E. Reynolds, M.D.
Medical Director

LOW-BACK PAIN

A CONSERVATIVE, FOUR-POINT PROGRAM

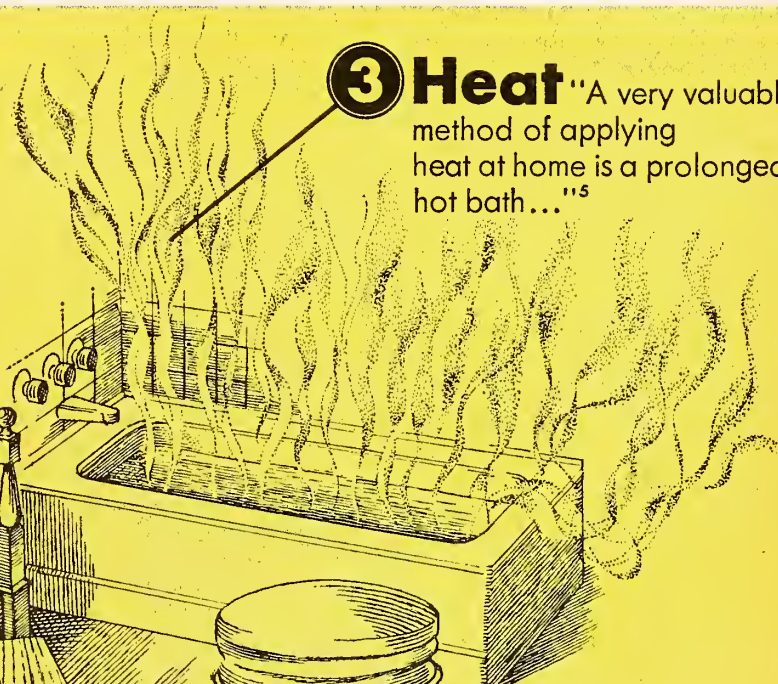
The low back pain that is most frequently seen in general practice is mechanical in nature, i.e., postural back pain, joint dysfunction and acute back strain.^{1,2} For this type of discomfort, a conservative regimen is usually sufficient to relieve aches and pains, and to help keep the patient functioning. Components of this basic program include:

1 Bed "If the patient is in the pain-spasm-cycle... there is no alternative or substitute for absolute bed rest..."³



2 Board "Boards should be ordered under the mattress... these boards act by immobilizing the spine..."⁴

3 Heat "A very valuable method of applying heat at home is a prolonged hot bath..."⁵



4 Robaxin®-750 (methocarbamol, 750 mg. capsule-shaped tablets) A well-tolerated⁶ skeletal muscle relaxant, methocarbamol helps relieve spasm "...without interfering with normal tone and movement."⁷ And there is little likelihood of sedation.⁶

Indicated for relief of skeletal muscle spasm. Contraindicated in hypersensitive patients. Side Effects (lightheadedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently. See product literature for further details. Also available: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)

References: (1). Godfrey, C.M.: Applied Therap. 8:950, 1966. (2). Gottschalk, L.A.: GP 33:91, 1966. (3). Rowe, M.L.: J. Occup. Med. 2:219, 1960. (4). Cozen, L.: South Dakota J. Med. 18:26, 1965. (5). Soto-Hall, R.: Med. Sc. 14:23, 1963. (6). Weiss, M. and Weiss, S.: J. Am. Osteopath. A. 62:142, 1962. (7). Feuer, S.G., et al.: New York J. Med. 62:1985, 1962.

A-H ROBINS A. H. ROBINS COMPANY
RICHMOND, VIRGINIA 23220



"Yes, Doctor, the pain is gone."

'EMPIRIN'® COMPOUND with CODEINE PHOSPHATE gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming),
Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

■ Despite introduction of synthetic substitutes, efficacy of 'Empirin'
Compound with Codeine remains unchallenged.

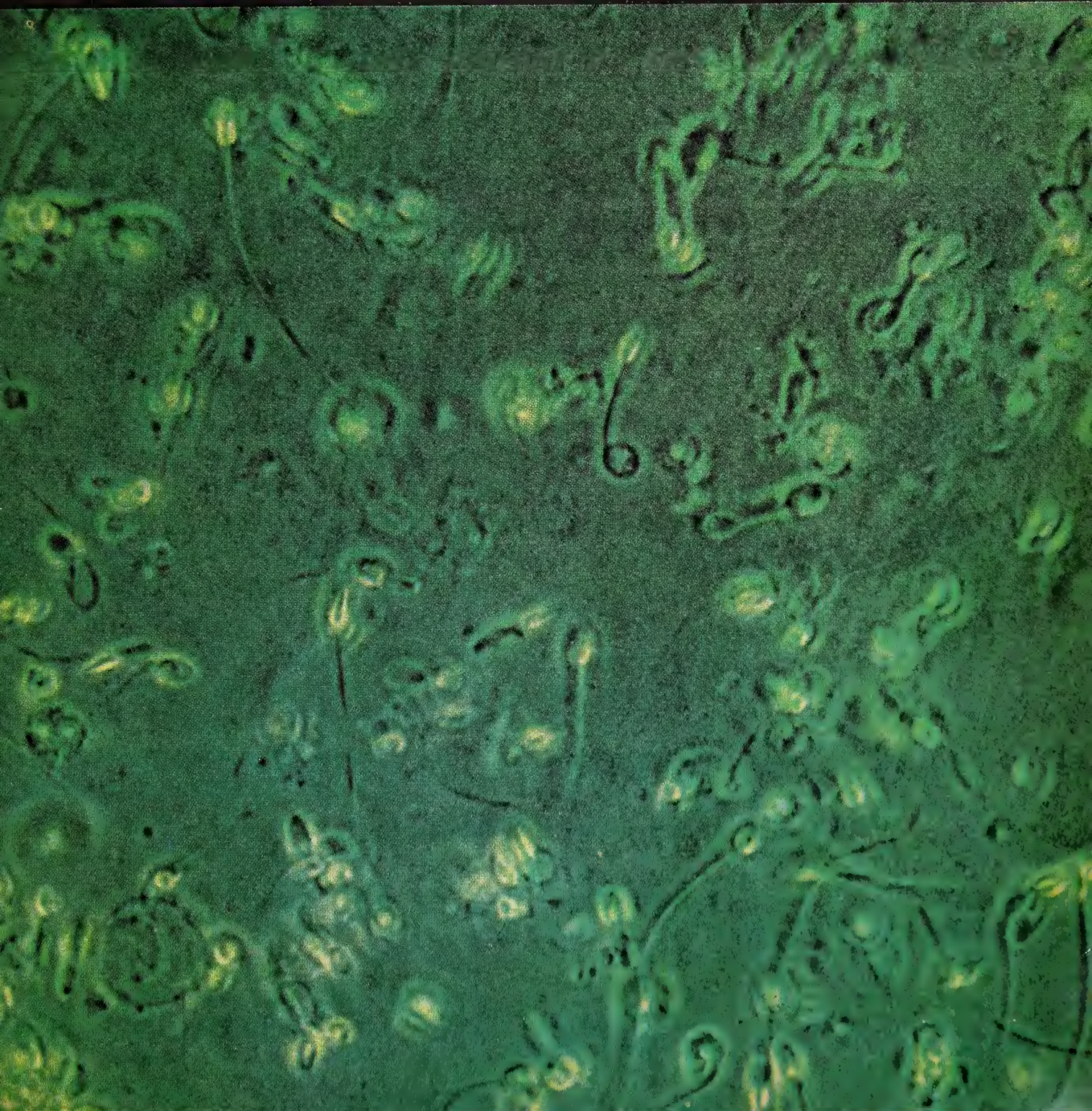


BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

When the talk turns to oral contraceptives, it makes medical sense to remember low-dose Norinyl-1.

(norethindrone 1mg, \bar{c} mestranol 0.05mg.)

Turn page for contraindications, precautions and side effects.



Reduction of oral contraceptive dosage to the lowest effective levels is a well-accepted principle of conservative medical practice. In keeping with this view, Norinyl is now also available as Norinyl-1, containing exactly one half the previous dosage of norethindrone and mestranol. Clinical experience has established that effective fertility control can be achieved with the same degree of reliability and safety with new Norinyl-1 when taken as directed.

What about switching patients from higher dosage forms?

In transferring patients to low-dose Norinyl-1 from higher-dosage oral contraceptives, some breakthrough bleeding may occur in the early cycles. In the majority of cases the bleeding episode is mild and self-limited. The long-term advantages of the lower dosage form should be weighed against the inconvenience of possible breakthrough bleeding in the individual patient.

Prescribing Information

Contraindications: Patients with any symptoms or history of thrombophlebitis, pulmonary embolism, liver dysfunction or disease, carcinoma of breast or genital organs, or undiagnosed vaginal bleeding.

Warnings: Discontinue medication pending examination if there is sudden partial or complete loss of vision, proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn. The safety of Norinyl-1 in pregnancy has not been demonstrated. If a patient misses two consecutive periods, pregnancy should be ruled out before continuing the medication. If she has not adhered to the prescribed schedule, pregnancy should be considered at the first missed period. Active ingredients of oral contraceptives have been detected in the milk of mothers who received these drugs; the significance to infants has not been determined.

Precautions: Pretreatment physical should include examination of the breasts and pelvic organs, as well as a Papanicolaou smear. If endocrine or liver function tests are abnormal during therapy, repeat tests are recommended after the drug has been withdrawn for two months. Following administration of drug, preexisting uterine fibromyomata may increase in size. Careful observation and caution are required for patients with symptoms or history of epilepsy, migraine, asthma, cardiac or renal dysfunction, cerebrovascular accident, psychic depression, and diabetes. In cases of undiagnosed vaginal bleeding, adequate diagnostic measures are indicated. Possible long-term effects of the drug on pituitary, ovarian, adrenal, hepatic or uterine function must await further studies. The physician should be alert to the earliest manifestations of thrombophlebitis and pulmonary embolism. The drug should be used judiciously in those young patients in whom bone growth is not complete. The age of the patient constitutes no absolute limiting factor, although treatment with Norinyl-1 may mask symptoms of the climacteric. The pathologist should be advised of Norinyl-1 therapy when relevant specimens are submitted.

Side Effects: The following have been observed with varying incidence in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, amenorrhea, edema, chloasma or melasma, breast changes (tenderness, enlargement and secretion), change in weight (increase or decrease), changes in cervical erosion and cervical secretions, suppression of lactation when given immediately postpartum, cholestatic jaundice, migraine, rash (allergic), rise in blood pressure in susceptible individuals, mental depression. Although the following side effects have been reported in users of oral contraceptives, no cause and effect relationship has been established: anovulation posttreatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, and itching. The following occurrences have been observed in users of oral contraceptives (a cause and effect relationship has neither been established nor disproved): thrombophlebitis, pulmonary embolism, neuroocular lesions.

The following laboratory tests may be altered by the use of oral contraceptives: increased sulfobromophthalein and other hepatic function tests, coagulation tests (increase in prothrombin, factors VII, VIII, IX and X), thyroid function (increase in PBI and butanol extractable protein-bound iodine and decrease in T^3 values), metyrapone test, pregnanediol determination.

norethindrone — an original steroid from
SYNTEX 
 LABORATORIES INC., PALO ALTO, CALIF.

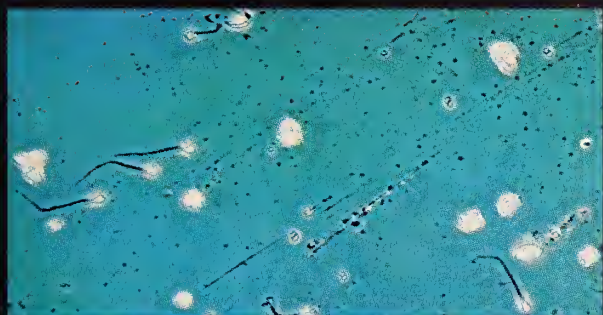
Here's why Norinyl-1 makes medical sense.

The effectiveness of Norinyl-1 as a low-dose oral contraceptive may be explained by its possible multiple action. In addition to its primary action of suppression of ovulation, Norinyl-1 may offer additional protective mechanisms... (1) creation of a cervical mucus that may be hostile to sperm penetration, and (2) development of an endometrium that may be out of phase with nidation. These effects are illustrated below.

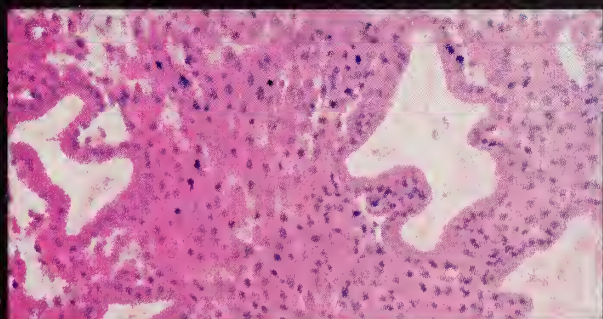
Untreated Patient



Cervical mucus at midcycle is usually thin and watery, with Spinnbarkeit (stretchability) of 15 to 20 cm.



Spermatozoa appear healthy, active, freemoving.

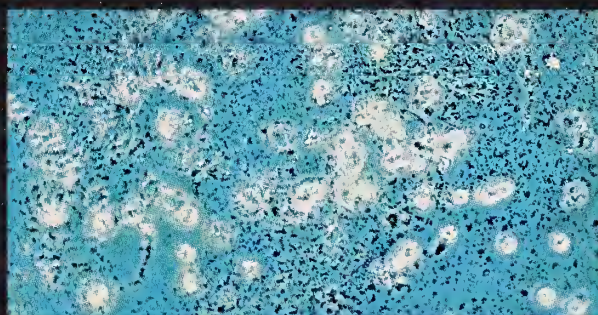


Endometrium of untreated patient is receptive to the fertilized ovum during secretory phase.

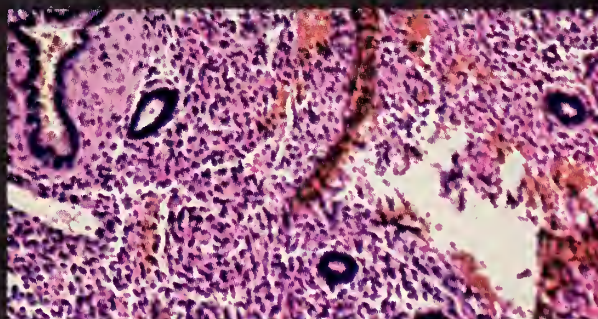
Norinyl-1 Patient



Cervical mucus at midcycle is scanty, viscous—with Spinnbarkeit of 1 cm. or less.



Immobile spermatozoa as they appear in cervical mucus taken from patient treated with Norinyl-1.



Norethindrone in Norinyl-1 accelerates secretory phase, suppresses glandular and vascular development.

Norinyl-1[®]
(norethindrone 1mg \bar{c} mestranol 0.05mg) tablets

- new low dose of time-proved ingredients
- established norethindrone/mestranol ratio
- lower patient cost

An uncommon steroid for common inflammatory dermatoses

In everyday topical steroid therapy, Synalar produces rapid resolution of inflammation and itching in steroid-responsive dermatoses—and at relatively low cost to the patient.

Advanced molecular design enhances potency

Synalar combines the advantage of earlier corticosteroid compounds with unique structural innovations. As a result, preparations of Synalar 0.01% and Synalar 0.025% have been reported to be more potent topically and significantly more effective than hydro-

cortisone 1.0%. The unique fluocinolone acetonide molecule provides one of the most useful topical corticosteroids for everyday practice.

Impressive clinical results in a wide range of dermatologic problems

The clinical efficacy of Synalar has been extensively documented in the world literature. Commonly encountered diseases such as allergic and contact dermatitis, eczematous and seborrheic dermatitis, and neurodermatitis respond rapidly to Synalar, often

where previous therapy with other topical corticosteroids has failed.

Low patient cost for wider usefulness

With Synalar, a high degree of efficacy does not mean high price. And—a small quantity goes a long way. Thus, your patients can often obtain the “economy” of a hydrocortisone preparation with the proved efficacy of a potent, truly advanced steroid.

Synalar®
fluocinolone acetonide





Turn page for contraindications, precautions and side effects

easy does it!

tear, moisten, compare—that's all!



Electrical cardiac pacing is effective despite infrequent disturbances in timing and rare infections, failure of metallic components and myocardial damage. An implantable wireless device with its own built-in power source is the hope of the future.

Cardiac Pacemakers

WILLIAM STORER, M.D.

A. D. DENNISON, Jr., M.D.

Indianapolis*

IT was in the late eighteenth century that Galvani discovered the action of electrical stimulation on muscle and Vassalli showed that electrical current had the same type effect on the human heart. This led to several experiments culminating in Gould's resuscitation of a baby's heart by inserting a needle electrode directly into the myocardium.¹⁸ The first report in literature on the use of pacemakers as they are currently utilized, was by Callaghan and Bigelow in 1951.³ They employed transvenous bipolar electrodes inserted through the right jugular vein into the right ventricular outflow tract of animals. In 1952 Zoll was the first to resuscitate a human heart with external pacemaking.²⁸

There are many indications for the institution of artificial pacemaking. In a summary on electrical pacing of the heart, Goetz stated that, in general, the indications for implantation of a pacemaker are a need for arous-

ing the heartbeat, and a need for increasing the rate of a heart with a pathologic bradycardia. More specifically, he lists the indications as: (1) continued and repeated Stokes-Adams seizures unresponsive to drugs; (2) atrioventricular block with acute myocardial infarction; (3) persistent congestive heart failure with slow ventricular rate or third degree heart block; and (4) surgical heart block.¹¹

Complete Heart Block

The most frequent indication for use of a permanent pacemaker is complete heart block. In a current series, Cosby compared previous cases of complete heart block treated with and without pacing. In 48 patients who were not paced, the mortality was 73% in the first year after development of the block. The mortality was 61.5% in a similar number of paced patients. Eighty-five percent of patients with complete heart block associated with myocardial infarction were dead in one year when unpaced, while 55% mortality occurred with paced patients.⁶ Although not reported in the literature, it has been suggested that artificial pacing may

be used for sinus bradycardia. There was one unpublished case reported in 1966 at the American College of Cardiology's annual meeting, and we have had a second case at Methodist Hospital, Indianapolis, Indiana.

Temporary pacemaking may be used in atrial fibrillation when there is a slow ventricular response. It has also been used to treat recurring ventricular tachycardia and fibrillation unresponsive to drugs.²⁷ Heiman reports two cases of ventricular arrhythmias causing syncope (not corrected with drugs or countershock) in which both responded to temporary rapid pacing with a transvenous pacemaker.¹³

The indications for artificial pacing are rapidly changing. As late as 1961, Dr. Zoll stated that, "Surgical implantation of cardiac pacemakers was undertaken in these patients only because seizures continued with desperate frequency and severity despite . . . adequate drug therapy."²⁰ Now, pacemakers are being implanted when only one seizure has occurred. Dr. Hughes Day of Kansas

* From the Department of Internal Medicine, Methodist Hospital Graduate Medical Center, 1604 N. Capitol Ave., Indianapolis 46207.

City uses temporary transvenous pacemakers in patients with myocardial infarction who develop second degree heart block in preparation for complete heart block should it occur.⁷

Types and Procedures

There are several available types of pacemakers and procedures of implantation. The external pacemaker was first used in humans by Zoll in 1952.²⁸ Again in 1955, he reported on the use of the external pacemaker and its preferred use in cardiac standstill over thoracotomy and direct cardiac massage.³¹ The external pacemaker relies on conduction of an electrical impulse through the chest wall from the skin to the myocardium. The impulse must be of sufficient strength to overcome the chest wall's resistance and as a result, the shocks are uncomfortable to the conscious patient. There also have been reports of myocardial damage after prolonged external pacing.^{21,23}

Some physicians have used a myocardial electrode inserted percutaneously for control of complete heart block and/or cardiac standstill. Lillehei's group reported a series in which silver wire electrodes were inserted through the chest wall into the myocardium in the immediate treatment of one episode of Stokes-Adams syndrome due to complete heart block or cardiac standstill. They experienced no difficulty inserting the wire electrode and each patient was successfully paced until the permanent pacemaker was implanted. They reported that, theoretically, this type of pacemaker could be used as a permanent one, but this has not yet been attempted. However, some of these patients have been successfully paced for periods up to 57 days.²⁶ In August, 1965, Lawrence presented a report favoring the percutaneous implantation over the temporary transvenous pacemakers. His reasons included the time required to catheterize the patient, the increased incidence of pulmonary emboli in transvenously paced patients, and the inci-

dence of right ventricle perforation with the electrode catheter.¹⁵

Transvenous pacemaking has become very popular as a temporary and permanent method of pacing. It has been shown that transvenous pacing from either a jugular, brachial or saphenous approach improves cardiac function. DeSanctis demonstrated that it improved congestive heart failure, allowed time for treatment of other medical problems, and permitted pacing throughout surgery, thus making the procedure much safer.⁸ Again, referring to Dr. Goetz' review, he believes that the best accepted treatment of a complete heart block is rapid insertion of a transvenous pacer via the brachial or jugular vein for temporary control of the situation. This method of management should be followed by implantation of a permanent pacemaker when the patient's medical condition allows a safe procedure.¹¹ Chardack feels that one should wait at least one month before implanting the permanent pacemaker because of intermittency of the problem. By waiting, some patients would no longer need pacemaking.³² There has been considerable discussion of the preference between a bipolar or unipolar electrode, but most report more advantages with a bipolar catheter. In its use there is no need for an indifferent skin electrode, less voltage drop across the electrodes is required with both electrodes in the ventricle, and both electrodes need not touch the endocardium.^{20,27} In fact, neither electrode need touch the endocardium if the impulse is great enough.³² The demand pacemaker, one which stimulates only when the intrinsic rate drops below pacemaker rate, is now very popular. The increase in complexity of wiring has not been a problem. The pacemaker should probably be considered in nearly every case where fixed rate pacers have been used. The only limitation of demand pacemakers is their availability.³²

Many have considered the use of radio waves to control electrodes im-

planted in the myocardium, thereby eliminating the need for wires and pacemaker implantation under the skin. Levitsky tried this with complete success in eight patients, but no further follow-up has been reported.¹⁶

Synchronous Pacing

Synchronous pacing, employing the impulse from atrial stimulation to fire the pacemaker causing ventricular contraction, has been advocated by some. The main advantages of this method are: the cardiac rate responds to body demands; atrial systole is followed by ventricular systole which has been shown to increase the cardiac index by 10-30%; and if normal A-V conduction returns, the pacemaker does not interfere.⁴ The artificial P-R interval is fixed at a greater interval than the intrinsic P-R; thus, if block disappears, the pacemaker does not interfere with normal conduction since the pacemaker impulse will occur when the ventricle is refractory.¹⁹ Brockman demonstrated an inverse relationship between end diastolic pressure and P-Q interval if the P-Q interval was greater than twelve seconds. He also noted increased end diastolic pressure in patients with synchronous pacers as compared to those with asynchronous pacemakers.²

Complexity is the principal disadvantage in the use of synchronous pacing. In addition, the greater number of wires increase the hazard of wire failure.⁴ Chardack commented that, "... the simplicity of an implantable device with a fixed pace outweighs the theoretical disadvantage resulting from the loss of adjustability of the rate."⁵

There have been several studies of cardiac function during electrical pacing. Judge showed that if the heartbeat was increased up to 75, there is a seven percent increase in cardiac output over that found at a rate of 60. A further increase of rate to 110 fails to increase the cardiac output. At a fixed rate, if the demands for increased cardiac output

are presented (as with exercise), the stroke volume alone increases. Three minutes of bike exercise, in supine position, with the ergometer at 700-1400 ft.-lbs./min., will cause an increase of cardiac output of 65%, even at a fixed heart rate.¹⁴ It also has been demonstrated that under these circumstances, norepinephrine or isoproterenol, due to their ionotropic effects, further increases the cardiac output.^{1,14}

Cardiac Drugs

When Groudin studied the effects of cardiac drugs in the presence of electrical pacemaking, isoproterenol was found to increase the phenomenon of competition discussed below. Digitalis also increases competitive rhythm. However, procaine amide in moderate doses decreased the incidence of competitive rhythm.¹²

Complications of artificial pacemakers are still significant. An electrical impulse delivered to the ventricle just after systole, or in the ascent of the T wave, (the vulnerable period), can cause repetitive ventricular contractions with resultant ventricular tachycardia or ventricular fibrillation. Tavel, Fisch, and Dressler, et al., reported cases of repeated episodes of ventricular tachycardia and fibrillation when the pacemaker impulse occurred during the upswing of the T wave of the preceding beat. This has been called competitive rhythm.^{10,25} This seems to be a paradox as it has been previously pointed out that the pacemaker impulse has far less voltage than is required to cause fibrillation. However, as Tavel noted, the compromised myocardium has a much lower threshold for fibrillation.

When the intrinsic rate of the patient's heart was increased from 58 to 75, the competitive rhythm disappeared.²⁵

Parasystole is sometimes produced when sinus rhythm returns during pacing and allows the pacemaker stimulus to fall in the vulnerable phase of some of the sinus beats. The mortality of patients with parasystole was five times that of patients with paced rhythm only. Sowton noted ventricular fibrillation occurring in five paced patients with parasystole. It should be mentioned, however, that the stimulus was ten times threshold.²⁴ Demand pacemakers nearly eliminate competition from the list of significant complications.³² Robinson reported a case in which the first implanted pacemaker functioned well until infection developed around the pacemaker. A second was implanted without removing the first and months later the original pacemaker began operating again, inducing competitive rhythm and fibrillation. With both pacemakers functioning, the rhythm was irregular, causing myocardial anoxia with a decreased threshold to ventricular arrhythmias. The patient did well as soon as the first pacemaker was removed.²²

Isoproterenol and epinephrine have been shown to accelerate idioventricular pacemakers, thereby suppressing ectopic ventricular activity leading to ventricular arrhythmias. For this reason these agents should be used in complete heart block until the control of the heart can be obtained with a pacemaker.^{9,17} Levophed has also been shown to stabilize the rhythm of the heart, as well as possess vasopressor activity, while phenylephrine has only vasopressor activity.³⁰

Two authors have reported damage

to the myocardium after prolonged external pacemaking. This damage consisted of hemorrhage and areas of inflammation. However, in one of these cases there were several episodes of chest pounding.^{21,23} In one patient who had had a transvenous pacemaker in place for one year, no endocardial damage was found during autopsy.²⁷

Ventricular Rupture

Ventricular rupture has been an ever present threat to the use of transvenous pacemakers. Three episodes of perforation have been reported, with two occurring when the tip was in the outflow tract and one when the tip was in the great cardiac vein.²⁷ Most ventricular perforations have very little clinical consequence.³² Infection has been another complication of pacemakers. Yuceoglu reports that in 96 transvenous insertions, five infections occurred; two were local at the cutdown site, two were septic and one was pneumonia with sepsis.²⁷ One patient had diaphragmatic jerks with each pace as the phrenic nerve had been incorporated into the electrodes.¹⁵ Pacemaker failure has been the greatest single failure. Circuit breakdown and/or wire breakage have been troublesome for years.¹⁵ The wire breakage usually occurs "... where the electrode enters the myocardium and the insulation directly abuts the epicardium."²¹⁶

The future of pacemaking is unknown. Hopefully, there will soon be an implantable wireless device with the capacity to generate its own power through motion of the heart itself. A device such as this will be limited only by life itself.¹⁸

(A copy of the references pertaining to this paper may be obtained by writing The Journal office.) ◀

An Addition to the Somatic Treatment of Alcoholism

J. R. MATTHEW, M.D.
Westville

METRONIDAZOLE was first synthesized by Jacob, Crisan and Regnier, and described by Durel (1959) for the treatment of trichomonas vaginalis and urethritis. No deaths or serious morbidity have been reported from its extensive use throughout the world. Manthei¹ demonstrated in 1963 that metronidazole inhibits dehydrogenase (ADH) in vitro.

The initial experience with the drug in the treatment of alcoholism was noted by Dr. Jo Ann Taylor in 1964 when metronidazole (250 mg. b.i.d. for 14 days) was instituted for trichomonas urethritis in a male. The wife, who also took the drug simultaneously for trichomonas vaginitis, reported that alcohol "tasted badly" during therapy.²

Dr. Taylor reported three courses of metronidazole therapy, illustrating that acute intoxication, alcoholic withdrawal and abstinence from alcohol should be considered as separate clinical and biochemical entities when studying the alcoholic and his reactions to drugs.

The favorable response to metronidazole as it relates to the alcoholic may be described as: Antabuse (disulfiram) reactions to overingestion of alcohol; favorable physical response to acute alcohol withdrawal phase; decreased compulsion to obtain alcohol; decreased tolerance per quantity of alcohol; changes in the central nervous system and psychic effects of alcohol; objective physical improvement on maintenance therapy

and development of an aversion to alcohol.

Advantages

Mild and moderate Antabuse reactions are proportional to the amount of alcohol ingested. The drug improves the hypermetabolic state of delirium tremens and patients have noted changes in their usual central and peripheral nervous system responses to alcohol. Prolonged treatment with the drug decreases the compulsive drive for liquor, and a combined aversion for alcohol develops. It was noted that only patients with pre-existing hypothyroidism, impaired androgenic function, or severe liver damage develop any potentially serious side-effects.

Drs. Semer and Friedland³ treated 26 cases at the alcoholic clinic in the Department of Psychiatry of Meadowbrook Hospital in 1966 for continuous periods ranging from two to 12 months. They noted that aversion and/or lack of desire for ethanol usually started in seven to ten days after initiation of therapy. Sometimes it occurred within 24 to 28 hours. Of the 26 patients treated, 24 have remained sober and productive on metronidazole for periods of from two to five months. The authors concluded that metronidazole, in divided doses of from 500 mg. to 750 mg. daily, appeared to consistently produce a marked aversion toward the ingestion of alcohol within two weeks in those patients well motivated in their desire to stop drinking.

R. Elosuo in the alcoholic clinic in Helsinki⁴ determined that metronida-

zole is a useful substance for interrupting the drinking period. G. Bonfiglio and G. Donadio⁵ treated 60 alcoholics in Rome with good results with metronidazole.

Dr. T. M. Itil⁶ from the Department of Psychiatry at the Missouri Institute of Psychiatry selected 11 schizophrenics for research in the use of metronidazole in 1966. His results suggest that metronidazole increases cortical excitability in chronic schizophrenics. Since other drugs such as Antabuse and LSD which are effective in alcoholism also have a central stimulatory action, these observations may help to elucidate the mode of action of metronidazole.

Case Report

A 52-year-old, married, furniture store co-owner was admitted to the hospital in December, 1964. He had been relegated to the basement department of the store by his brothers due to his excessive drinking pattern and he had been a patient on two other occasions in a state psychiatric hospital for the treatment of alcoholism.

He was given two leaves during his stay at our hospital and on both occasions was readmitted because of recurrence of his drinking problem. He was severely disturbed upon his first return to the hospital and cut his throat in an attempted suicide. On his second readmission, he suffered a fractured arm.

In view of the resistance of the family to his discharge and his repeated drinking pattern, it was de-

* Staff psychiatrist, Dr. Norman M. Beatty Memorial Hospital, Westville 46391.

cided to treat him with metronidazole. He was placed on the drug (250 mg. b.i.d.) two weeks before he was allowed to go home. Subsequent letters from himself and his wife verify the improvement in his drinking problem and he has returned to work. He states in the letters that his physical and mental well-being are much improved.

Summary

Metronidazole was used in the treatment of a difficult alcoholic patient in a state psychiatric hospital. Glowing reports were received from relatives and the patient himself as

to the improvement of his physical and mental well-being. This medication will be used again in selected cases. It is becoming a proven adjunct in the treatment of the alcoholic patient.

REFERENCES

1. Manthei, R. W.: The Metabolism of Metronidazole (Flagyl), *The Pharmacologist* 4:170, No. 2, 1962.
2. Taylor, Jo Ann.: Metronidazole—A New Agent for Combined Somatic and Psychic Therapy of Alcoholism, *Bull. Los Angeles Neurol. Soc.* 29:158-162, (Sept.), 1964.
3. Semer, Martin, et al.: The Use of Metronidazole in the Treatment of

- Alcoholism. A Pilot Study, *Am. J. Psychiat.* 123:722-724, (Dec.), 1966.
4. Elosuo, R.: Metronidazole in the Treatment of Alcoholism, *Suomen Lääkärilehti* 27:2178-2181, (Sept.), 1966.
5. Bonfiglio, G., Donadio, G.: Results of a Clinical Trial with A New Compound, Metronidazole, In the Treatment of Chronic Alcoholism, *I Lavoro Neuropsichiatrico*, Vol. 38, Part II, (Dec.), 1966.
6. Itil, T. M.: The Clinical and Electroencephalographic Effects of Metronidazole in Schizophrenic Patients, AAS Symposium, Washington, D.C., *Recent Research in Alcoholism*, 26-27, (Dec.), 1966. ◀

Share Your Medical Journals With Colleagues Overseas

The doctors of the U.S.A. are being asked to send their medical journals—after they have read them — to colleagues overseas (Asia, Latin America, and Africa) who wish to have access to current medical literature but, either because of currency regulations or actual cost involved, cannot themselves subscribe to medical periodicals. We can supply you with the name, address, and medical specialty of doctors in these areas who would be happy to receive these much wanted journals, (*particularly specialty journals*), which you will mail direct to your overseas colleague.

This is a direct "Doctor-to-Doctor" program which is being sponsored by the American Medical Association with the collaboration of The World Medical Association to help alleviate the lack of current medical publications and to further international good will. Your cooperation in this program will be greatly appreciated and your contact with these colleagues in other countries, we can assure you, will prove very gratifying. If you wish to participate in this program, send your name, address, and titles of journals you will contribute to DOCTOR-TO-DOCTOR PROGRAM, Ada Chree Reid, M.D., Director, c/o The World Medical Association, Inc., 10 Columbus Circle, New York, New York 10019.

Aneurysm of the Hepatic Artery: Report of a Case

KENNETH L. SCHERMER, M.D.
Portsmouth, Virginia*

ANEURYSM of the hepatic artery is an uncommon pathologic condition. Smyth and Teimourian report a total of 143 cases, 36 of which were successfully treated by surgery.¹¹ The majority of these 143 cases, prior to exploratory laparotomy or postmortem examination, were not clinically recognized. With the use of arteriographic technics and arterial surgical procedures, more of these aneurysms are now being accurately diagnosed and treated.

Case Report

The patient was a 62-year-old hypertensive female. Cholecystectomy had been performed four months prior to her demise. In the two months prior to admission, she had experienced episodes of nausea and vomiting with increasing frequency, and had lost 18 pounds. The patient developed jaundice with acholic stools and "Coca-Cola colored" urine. The patient denied melena or hematemesis. The provisional diagnosis was obstructive jaundice, probably due to common duct stones.

Exploratory laparotomy revealed a large cystic mass in the general area of Morison's pouch. Dark blood was aspirated from the mass and attempts to mobilize it resulted in spontaneous rupture and a moderate amount of hemorrhage. The patient suffered a cardiac arrest and expired.

At autopsy, the body was markedly icteric. On opening the abdominal cavity, free blood was noted. A 6 cm. aneurysm of the hepatic artery was

identified. Obstruction of the common duct by the aneurysm with proximal dilatation was present. The aneurysm was adherent to the gallbladder bed, stomach and duodenum (Figures 1, 2).

Microscopic examination of the aneurysm revealed compressed fibrous tissue, lined by laminated thrombus. Muscle could not be identified in the aneurysm. The liver demonstrated bile duct rupture with bile lakes, liver cell necrosis, and infiltrates of lymphocytes and macrophages. Bile plugs and bile duct proliferation were present. These changes were interpreted as early biliary cirrhosis due to common duct obstruction. The cause of death was acute hemorrhage from a false aneurysm of the hepatic artery with cardiac arrest.

Discussion

Smith et al.,¹⁰ state, "A true aneurysm is a localized dilatation of an artery due principally to weakening of the media. A false aneurysm is a blood-filled space adjacent to and communicating with an artery through an abnormal hole in the wall of the artery. A false aneurysm is lined by thrombus and compressed tissue." Hepatic artery aneurysms may be of either type.

Aneurysms of the hepatic artery are found in males three times more commonly than in females and the average age is 38 years.¹⁴ A clinical triad of jaundice, right upper quadrant pain, and gastrointestinal hemorrhage is well known.^{1,7} Aneurysms are located both intrahepatic and extrahepatic, with the extrahepatic



FIGURE 1

THE right lobe of the liver has been removed. The stomach, which has been opened, lies to the left. The white arrow is placed on the aneurysm. Biliary cirrhosis is present on gross examination.

*From the Department of Pathology, Naval Hospital, Portsmouth, Va. 23708.

site being more common. Fifty percent of the extrahepatic aneurysms involve the main hepatic artery,¹⁵ with 33% in the right branch, 10% in the left branch, and the remainder in the cystic artery, accessory arteries, or a combination of arteries.⁸

Eighty percent of the hepatic artery aneurysms eventually rupture,¹ with hemorrhage into the abdominal cavity or the gastrointestinal tract, including the bile ducts.⁷ Approximately 50% bleed into the abdominal cavity.⁸

The most common causes of hepatic artery aneurysms are reported as: infection (60%), arteriosclerosis (22%), and trauma (10%).¹⁵ The trauma category includes both accidental⁴ and inadvertent surgical damage.⁷ Some authors believe that arteriosclerosis is the most common cause.^{3,11} Inui and Ferguson state that a hepatic artery aneurysm should be considered in cases with clinical evidence of bleeding following operation upon the biliary tract.⁴

Filling defects of the duodenum are reported on upper gastrointestinal x-ray examination.² Jarvis and Hodes report that roentgenographically 40 of 88 aneurysms demonstrated calcified material in the wall.⁶ Pleas for arteriogram studies of patients with suspected aneurysm are made by several authors.¹²⁻¹⁵ These techniques can specifically define and locate these lesions.

Surgical excision and re-establishment of vascular continuity should be the treatment of choice. In some cases where artery ligation is performed the patient may continue to bleed.² Surgical ligation also raises the problem of liver necrosis. It is stated that ligation of the celiac axis or hepatic artery proximal to the gastroduodenal artery rarely leads to total liver necrosis; however, ligation of the hepatic artery distal to the gastroduodenal and right gastric branches eventually results in death from liver necrosis or failure.⁸ Thorley et al. report a case in which accidental ligation of the right hepatic artery at the

time of cholecystectomy resulted in massive necrosis of the right lobe of the liver and death of the patient.¹⁵ Shohl, however, reports a case in which the hepatic artery was ligated distal to the gastroduodenal branch. This patient was treated with large amounts of antibiotics and survived.⁹

In an interesting recent article, Jacobsen et al. report that using hyperbaric equipment, (4ATA 100%O₂) the dog liver can be protected against periods of total inflow occlusion up to 120 min.⁵ Such a period of time should allow the vascular surgeon adequate time to perform surgical excision and re-establishment of vascular continuity in the majority of cases.

Summary

The clinical and radiographic findings of aneurysms of the hepatic artery are presented. A case report is presented to illustrate the pathological findings. Surgical removal and re-establishment of vascular continuity is believed to be the treatment of choice.

REFERENCES

1. Browning, L. D., Jr., Clauss, R. H.,

MacFee, W. F.: Aneurysm of the hepatic artery: Report of two cases, *Ann. Surg.* 150:320, 1959.

2. Bruwer, A. J., Hallenbeck, G. A.: Aneurysm of hepatic artery: Roentgenologic features in one case, *Am. J. Roent. Rad. Ther.* 78:270, 1957.
3. Hansbrough, E. T., Lipin, R. J.: Hepatic artery aneurysm with excision of celiac axis, *Ann. Surg.* 149:273, 1959.
4. Inui, F. K., Ferguson, T. A.: Aneurysm of the right hepatic artery. Preoperative diagnosis and successful excision, *Ann. Surg.* 144:235, 1956.
5. Jacobsen, D. S., Schwartz, S. I.: Effect of hyperbaric oxygenation on hepatic inflow occlusion, *Surg.* 58:364, 1965.
6. Jarvis, L., Hodes, P. J.: Aneurysms of the hepatic artery demonstrated roentgenographically: A case report, *Am. J. Roent. Rad. Ther.* 72:1037, 1954.
7. MacDonald, J. A., Baker, C. B., Welsh, W. K.: Hepatic artery aneurysm: Report of a case, *Ann. Surg.* 161:94, 1965.



FIGURE 2

THE anterior margin of the liver and the stomach have been removed. The aorta lies to the left. The white arrow in the lower left identifies a probe placed in the hepatic branch of the celiac axis. The artery enters the aneurysm medially. The white arrow marks the exit superiorly.

8. McCarriston, J. R., Alin, G. E., Crowell, D. E.: Splenohepatic arterial anastomosis for aneurysm of hepatic artery, *Surg.* 47:636, 1960.
9. Shohl, T.: Hepatic artery ligation for massive hemobilia, *Surg.* 56:855, 1964.
10. Smith, E. B., Beamer, P.R., Vellios, F., Schulz, D. M.: *Principles of Human Pathology*, Oxford University Press, New York, 1959. p. 662.
11. Smyth, N. P. D., Teimourian, B.: Resection of hepatic arterial aneurysm following intraperitoneal rupture. Report of a case with recovery, *Ann. Surg.* 150:61, 1964.
12. Steelquist, J. H.: Aneurysm of the hepatic artery. Report of three cases, *Am. J. Surg.* 89:1241, 1955.
13. Steinberg, I.: Diagnosis of aneurysm of the hepatic and splenic arteries by intravenous abdominal aortography, *New Eng. J. Med.* 263:341, 1961.
14. Steinberg, I., Finby, N., Evans, J. A.: Intravenous abdominal aortography in the diagnosis and differential diagnosis of aneurysms of the splenic, hepatic and renal arteries, *Am. J. of Roent. Rad. Ther. and Nuc. Med.* 86:1108, 1961.
15. Thorley, L. G., Figiel, L. S., Figiel, S. J., Rush, D. K.: Roentgenographic findings in accidental ligation of the hepatic artery: A case report, *Rad.* 85:56, 1965. ◀



The editor and the staff of

The Journal wish you all

a Very Merry Christmas and

a Peaceful, Happy New Year

Merry Christmas

Electrocardiogram of the month



Presented as a regular feature of *The JOURNAL*, *Electrocardiogram of the Month* is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.

A-V Nodal (Junctional) Tachycardia in Emphysema

CHARLES FISCH, M.D.
Indianapolis

AS was pointed out in the October, 1967 ECG of the Month, patients with chronic obstructive pulmonary emphysema (COPE) frequently develop supraventricular arrhythmias, most often various forms of paroxysmal atrial or nodal (junctional) tachycardias and rarely atrial fibrillation or flutter.

Figure 1 demonstrates supraventricular tachycardia, probably nodal and right ventricular hypertrophy (RVH) in a patient with COPE. The ECG taken on 2-5-64 shows the S-1, S-2 and S-3 pattern frequently seen in COPE and the hallmark of RVH.

namely the qR pattern in V-1. On 2-17-64 the atrial focus has shifted as indicated by change in the morphology of P in leads 2, 3 and inversion in V-1. On 2-10-64 the atrial rate is increased to 100, the

P waves are now inverted in II, III and V-1. the PR prolonged to .22. The inverted P waves indicate an A-V nodal (junctional) origin of the rhythm and the rate of 100 classifies it as an A-V nodal tachycardia.

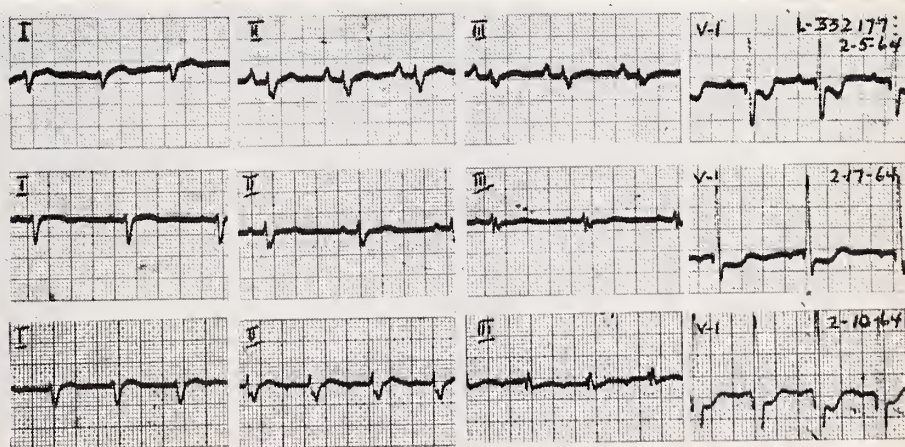


FIGURE 1
RVH and A-V nodal (junctional) tachycardia in a patient with COPE.

Arteriographic Demonstration of Parathyroid Adenoma

ERICH K. LANG, M.D.
Indianapolis*

A 32-year-old white male was admitted to the hospital with complaints of muscular weakness, hypotonia, lack of appetite, nausea, polydipsia and polyuria. A flat plate of the abdomen and intravenous pyelogram demonstrated nephrocalcinosis. A bone survey was performed because of the suspicion of hyperparathyroidism and areas of "lace-like" subperiosteal reabsorption along the medial circumference of the clavicles were demonstrated. Similar findings were present in the phalanges, although less clearly identifiable. There was no radiographic evidence of bone cysts, fractures, or compression fractures of the vertebrae. Poor oral sanitation precluded assessment of the lamina dura.

Blood chemistry examinations revealed marked elevation of serum calcium and phosphatase. The serum phosphorus level was low. Urinary calcium and urinary phosphorus were both high. The composite picture was quite characteristic of hyperparathyroidism, however, physical examination of the neck failed to show a mass suggestive of a parathyroid adenoma.

A selective arteriogram of both the right and left inferior thyroidal artery was carried out. If negative, a selective external carotid arteriogram of the right and left external carotid

artery was contemplated for further assessment of the retrothyroidal and parathyroidal region.

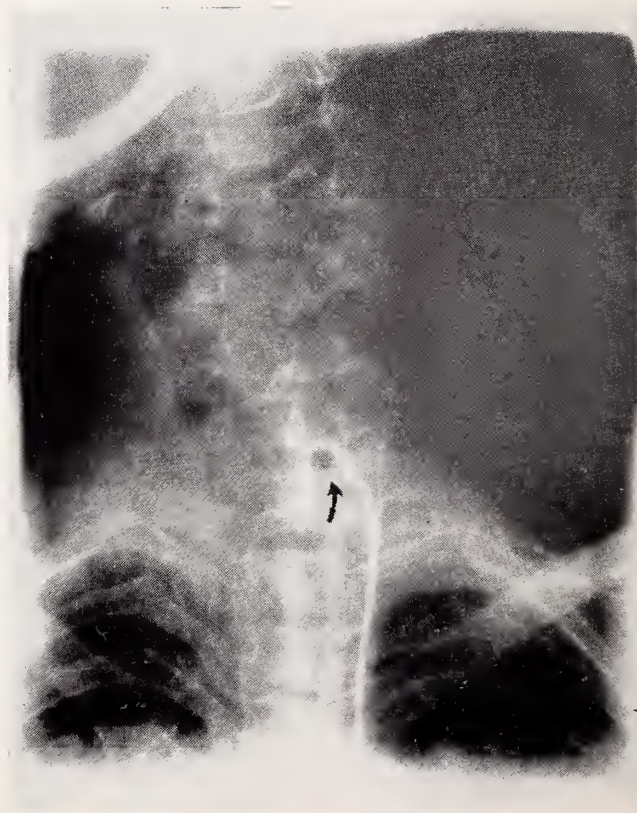
The left inferior thyroidal arteriogram, however, demonstrated the classical changes associated with a parathyroid adenoma (Figure 1). The first cephalad loop formed by the inferior thyroidal artery should be narrow; the diameter in the adult should be no greater than one-third of the cross diameter of the body of C-7 in this particular projection. In this case, the loop was obviously

widened. The cross diameter exceeded one-half of the measurement derived from the cross diameter of the body of C-7. On basis of this observation, it was postulated that the parathyroid adenoma was located in the left inferior parathyroid gland.

Surgical exploration was greatly facilitated by this knowledge and readily confirmed the presence of a parathyroid adenoma, measuring 1.8 x 1.7cms. The parathyroid adenoma was removed without diffi-

FIGURE 1

A selective arteriogram of the left inferior thyroidal artery demonstrates widening of the first loop of this vessel. A reference measurement to the width of the 7th cervical vertebra reveals the loop to measure more than one-half of the cross diameter of the vertebral body of C-7 along its base diameter. This is considered to reflect significant splaying and enlargement of the base of the loop, most likely caused by an adenoma of the respective parathyroid gland.



* Radiologist, Methodist Hospital, Indianapolis 46207.

culty, and the patient's recovery was uneventful.

Comment

Classical clinical symptoms and signs and usually reliable laboratory data establish the diagnosis of hyperparathyroidism with confidence. However, the actual localization of the parathyroid adenoma may meet with vexing problems. In many cases, complete thyroidectomy and resection of all parathyroids had to be carried out because the offending parathyroid adenoma could not be found during surgical exploration.

Barium swallows and even lamino-

grams of the lower neck area have been utilized, hoping to identify a mass. However, only unusually large parathyroid adenomas can be identified in this fashion. Selective arteriography of the inferior thyroidal arteries has given us the first reliable tool for the assessment of the lower pair of parathyroids. The inferior thyroidal artery forms a constant loop around the lower parathyroid, and enlargement of this structure is, therefore, necessarily associated with widening and splaying of this loop.

In this case, a definitive diagnosis of adenoma of the parathyroid gland of the lower pair can be made with great reliability. The upper pair is

more difficult to identify on arteriograms, although in some instances, a very definitive blush may identify the adenoma following selective opacification of the external carotid artery.

Both the right and left inferior thyroidal artery are readily amenable to selective catheterization. The left inferior thyroidal artery is opportunely engaged by a straight catheter, introduced into the right femoral artery, utilizing a bayonet-shaped guide wire. The right inferior thyroidal artery is readily engaged with an S-shaped catheter and a bayonet-shaped guide wire, utilizing the same point of entry. ◀

Correction

To The Editor:

The wording in one place in the article by myself and Dr. John Pittman entitled "Mediastinoscopy—A Safe, Practical Technic" (*JISMA*, October, 1967) may convey the wrong impression.

The last two sentences of the second paragraph on page 1362 read as follows: "In Boerema's experience, prior to the use of mediastinoscopy, pulmonary resection with a cure occurred in only 60% of thoracotomies. When mediastinoscopy was employed prior to surgical resection, a cure occurred in more than 90% of cases."

We believe a more exact wording should be as follows: "In Boerema's experience, prior to the use of mediastinoscopy, pulmonary resection with a hope for cure occurred in only 60% of thoracotomies. When mediastinoscopy was employed prior to surgical resection, hope for cure occurred in more than 90% of cases."

Please publish this as a matter of information and correction.

Harry Siderys, M.D.
Indianapolis

FRACTURES AND ORTHOPEDIC PROBLEMS

"Fractures and Orthopedic Problems" is a feature which will appear regularly. It will outline conditions involving bones and joints which will be of interest to physicians in general and special types of practice. It will be edited by George F. Rapp, M.D. of Indianapolis. The submission of short illustrated articles to this feature is invited.

The Recognition and Treatment of Dupuytren's Contracture

JAMES B. WRAY, M.D.
Indianapolis*

NODULE formation in the palm associated with flexion contractures of the digits was first attributed to pathological changes in the palmar fascia by the French surgeon, Dupuytren. In the interval between Dupuytren's original description and the present era, much progress has been made in the treatment of the disease but the etiology of the condition remains obscure.

Dupuytren's contracture is most commonly seen in individuals ranging from 40 to 60 years of age. It occurs more frequently in the male than in the female and is found in both hands approximately 50% of the time. The cause of the disease is unknown and there is no evidence to substantiate the occasional claim that the deformity is produced by occupational trauma to the hands.

The tissue changes responsible for the deformities of the disease have attracted the attention of several writers.^{1,2} In brief, nodules form in the palmar fascia and in the deep fascia over the volar surfaces of the proximal phalanges as these tissues show vigorous local proliferative activity. As the nodules mature they send out fibrous extensions which hypertrophy and shorten, producing

flexion contractures of the digits.

The well developed case of Dupuytren's contracture is easily recognized (Figure 1). In this case, a severe flexion deformity of the ring finger has resulted from the contraction of

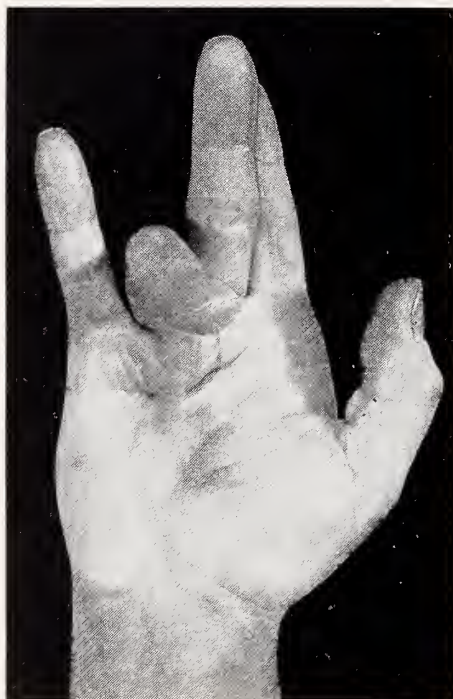


FIGURE 1

A typical case of Dupuytren's contracture. The ring finger has been drawn into an acute flexion deformity by a fibrous band that extends from the fascia of the midpalm to the fascia overlying the volar aspect of the proximal phalanx. Such bands have their origin in fibrous nodules in the palm. The dimpling of the skin at the base of the ring finger signifies that the disease has invaded the palm. Overzealous surgical dissection here may produce necrosis of the skin in this area.

fibrous bands originating in palmar nodules and extending into the fascia over the proximal phalanx. Localization of the process to the ring finger is quite common. Little finger involvement is equally common. Long and index fingers are affected less often and the thumb least of all.

In this particular case, both ring finger and thumb were involved although the ring deformity was much more severe.

The skin is frequently involved in the more severe cases of Dupuytren's contracture. A close glance at Figure 1 will reveal dimpling of the palmar skin at the base of the ring finger, indicating that the skin has been invaded by the disease process. This observation is of considerable therapeutic significance for it suggests that surgical excision of the underlying fibrous tissue may be difficult. Surgery in such cases may be followed by delayed wound healing and stiffness of the hand unless it is performed with utmost care.

Surgical Management

The treatment of Dupuytren's contracture has passed through several phases during the last 40 years. At times non-surgical management has been advocated. Measures ranging from the administration of vitamin E to deep x-ray therapy have had their

* Professor and chairman, Department of Orthopaedic Surgery, Indiana University Medical Center, Indianapolis 46207.

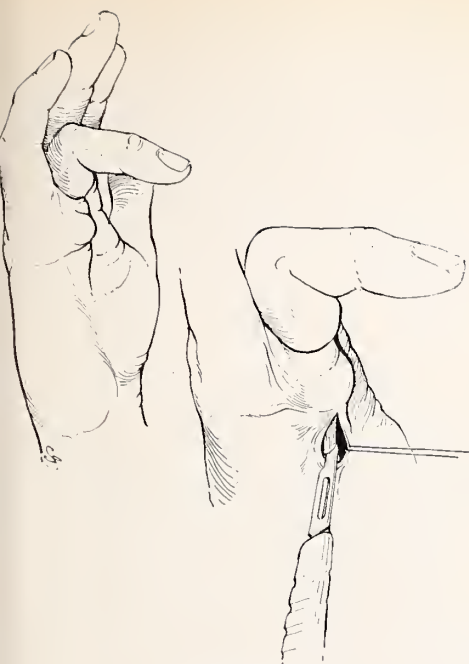


FIGURE 2

THE technic employed of surgery is shown here. Either local or brachial plexus block anesthesia is satisfactory and a tourniquet is applied to minimize bleeding and allow clearer visualization of the deep structures. Small longitudinally arranged incisions are made alongside contracted bands or nodules. The skin is carefully dissected away and the band sectioned or the nodule excised with a small bladed scalpel. A second operation may be necessary in those cases that cannot be fully corrected with the first procedure. Such surgery can be performed on an outpatient basis or at most with one to two days hospitalization.

advocates. Manual stretching of deformities has been tried. At the present time, however, it is clear that all such treatment technics have been ineffective in the correction or prevention of deformity and that surgery offers the only chance for the successful management of the disease.¹

In general, two types of surgical management have been employed in the past: radical excision of the palmar fascia; and limited excision of nodules combined with section of contracted bands. Radical, or complete excision, was commonly advocated during the decades following 1930 and 1940 but has few adherents today. Patients with Dupuytren's contracture are prone to develop postoperative stiffness. All too often total excision of the palmar fascia has been associated with vary-

ing amounts of permanent finger stiffness. In other instances necrosis in the palmar skin has followed overzealous surgery in the hand with extensive skin involvement.

Excision of nodules in association with the section of contracted bands was advocated by Luck² and is currently enjoying widespread popularity. This technic is very rarely followed by limited joint motion or skin necrosis and has been highly satisfactory in all but those deformities so severe as to require amputation of the involved digit.

The author has used a modification of the method of Luck with success for a number of years. The details of this technic may be best illustrated with an illustrative case.

Case Report

The patient, a 50-year-old white male, noted the appearance of nodules in the palm of the right hand and the gradual development of a flexion deformity of the ring finger over a six-year period. There was a severe flexion contracture of the ring finger and a prominent fibrous band in the palm and skin dimpling over a large nodule at the base of the ring finger (Figure 1). A second nodule with less prominent band formation was found at the base of the thumb.

The patient was taken to surgery where a brachial plexus block was performed and the palmar band was sectioned through two small longitudinal incisions in the palm (Figure 2). Skin closure was accomplished with fine steel wire sutures and a pressure dressing applied.

Twenty-four hours after surgery, the pressure dressing was removed and a small waterproof dressing applied over the incisions. Warm, soapy water soaks to the hand were carried out three times daily for



FIGURE 3

ELEVEN months after the last of two limited surgical procedures, the hand (previously seen in Figure 1) is normal in appearance and function. Note that the dimpling of the palmar skin at the base of the ring finger has been corrected.

periods of 20 minutes. The patient was encouraged to move his fingers and a hand splint was utilized between exercise periods to stretch the ring finger into extension.

Four weeks after the first surgical procedure, the flexion contracture of the ring finger had been corrected by 50% of the original deformity. The patient was taken back to the operating room where the nodule at the base of the ring finger was excised through a small longitudinally arranged incision. The postoperative regime of the first surgery was repeated.

Within three days of the second procedure, the flexion contracture of the ring finger was almost completely corrected. Eleven months later (Figure 3) there was no recurrence of the deformity and hand function was excellent.

This case is particularly valuable in that it illustrates three basic principles of therapy. First, surgical procedures used in the management of Dupuytren's contracture should be

limited enough to avoid skin necrosis and to permit active digital motion within a few hours of operation. The use of steel sutures and small longitudinally arranged incisions avoids wound problems that might result from digital motion superimposed upon large, transversely arranged incisions.

Second, the interval between multiple operations should be great enough to permit the hand to regain full preoperative digital motion. During this interval, correction gained with the first surgery is maintained by the use of splinting.

Third, surgery should be performed early to avoid complications and to accomplish a satisfactory correction of the deformity. Ideally, the case presented here should have been corrected before the flexion contracture had become severe. It is highly likely that early surgery would have avoided the necessity for a second



FIGURE 4
WHEN the patient cannot approximate his palms to the position adopted in prayer the deformities of Dupuytren's contracture are severe enough to warrant surgical correction. In this case the ring finger of the right hand has a moderately severe contracture that prevents approximation of the palms. A single surgical procedure combining section of a contracted band and excision of one nodule allowed satisfactory correction.

operation. In this regard, the author has found the "prayer sign" to be most helpful in determining when the deformity warrants surgery (Figure 4). When the deformity or deformities are so severe as to preclude the assumption of the prayer position by the hands, surgical treatment is indicated.

Summary

Dupuytren's contracture is a common disease in the middle-aged male and may produce serious hand disability if it goes uncorrected.

Conservative measures are useless in the management of the disease. Surgical correction should be carried out when the deformities preclude the approximation of the palms in the prayer position.

BIBLIOGRAPHY

1. *Bunnell's Surgery of The Hand*, revised by J. H. Boyes, 4th Edition, J. B. Lippincott Co., Philadelphia, 1964.
2. Luck, J. V.: Dupuytren's Contracture, *J. Bone Joint Surg.* 41A:4, 1959. ◀

**I.U. School of Medicine Postgraduate Courses
(Division of Postgraduate Medical Education)**

DATE	COURSE TITLE	LOCATION	COURSE DIRECTOR	A.A.G.P.* HOURS
Jan. 10	Common Problems in Cardiology	Marion County General Hospital	Charles Fisch, M.D.	8
Jan. 24	Office Endocrinology	I.U.M.C.	William P. Deiss, M.D.	8
Jan. 25	Emotional Problems in General Hospital Practice	Protestant Deaconess Hospital, Evansville	H. Jerome Rietman, M.D.	4
Feb. 7	Anesthesiology for the General Practitioner	I.U.M.C.	Vergil C. Stoelting, M.D.	8
Feb. 14	Emergency Care of the Trauma Patient	Marion County General Hospital	Paul Benedict, M.D.	8
Feb. 28	Management of Liver Disorders	I.U.M.C.	Philip Christiansen, M.D.	8
Mar. 20, 21, 22	Electrocardiography for Physicians	I.U.M.C.	W. Donald Close, M.D.	24
March 27	Practical Management of Pulmonary Diseases	I.U.M.C.	Roy Behnke, M.D.	8
April 24	Emotional Problems in Family Practice	Dunn Memorial Hospital, Bedford	Donald Kerr, M.D.	5
May 8	Orthopaedics for the General Practitioner	I.U.M.C.	James Wray, M.D.	8

* Prescribed hours credit by the American Academy of General Practice

Eaton Agent

Endamoeba histolytica

Hemophilus influenzae

Pneumococcus

Escherichia coli

Gonococcus

Shigella

Staphylococcus

Streptococcus

Rickettsia

Treponema

If there's a broader susceptibility pattern of organisms, we've yet to see it.

DECLOMYCIN has always belonged in the foremost rank of the broad-spectrum, general-purpose antibiotics. Indeed, no antibiotic has yet appeared which controls a wider range of pathogens responsible for the clinical infections seen in the day-to-day practice of busy medical men.

You can depend on DECLOMYCIN. A twice-daily dose of 300 mg is a sensible schedule that will cover the patient *day and night*, without risk of blood concentrations dropping below therapeutic levels. This is because of high serum binding and slow renal clearance.

And there is no need to give higher daily dosage than 300 mg b.i.d., except in venereal diseases and Eaton Agent pneumonia.

DECLOMYCIN[®]
DEMETHYLCHLORTETRACYCLINE

Lederle

Prescribing information on next page.

Endamoeba histolytica

Hemophilus influenzae

Pneumococcus

Escherichia coli

Gonococcus

Shigella

Staphylococcus

Streptococcus

Rickettsia

Treponema

If there's a broader susceptibility pattern of organisms, we've yet to see it.

DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines when the offending organisms are tetracycline-sensitive.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning—In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions—Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects—Gastrointestinal system— anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes. A rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs discontinue medication and institute appropriate therapy.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

In the treatment of syphilis a dosage schedule of a total of 12 to 18 Gm. given in equally divided doses over a period of 10 to 15 days should be followed. Close follow-up observation of the patient is recommended, including appropriate laboratory tests, since demethylchlortetracycline has not had adequate evaluation in all stages of syphilis. Spinal fluid examination should be included as part of this follow-up.

Acute gonococcal anterior urethritis in males has been treated effectively with a single dose of 600-900 mg. of DECLOMYCIN Demethylchlortetracycline. Individuals unable to tolerate large single doses due to gastrointestinal side effects may be treated with 150 mg. every 6 hours for a minimum of 4 doses or 300 mg. every 12 hours for a minimum of 2 doses. Females should be treated with a dosage of 150 mg. every 6 hours or 300 mg. every 12 hours until a cure is effected. Primary Atypical Pneumonia (Eaton Agent): The average adult daily dosage is 900 mg. in 3 divided doses for six days.

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, N.Y.



PATRICK A. DOLAN, M.D.
Indianapolis*

The Cancer You View

Edited by

Edwin E. Pontius, M.D.

Indianapolis

A 50-year-old woman went to a physician complaining of a lump in her breast. Palpation revealed a 3.5 cm. mass in the left breast.

What further examinations may help in specific diagnosis prior to surgery?

What ancillary information may be provided by the examination?

For diagnosis and discussion, please see page 1705.

* Director, Department of Radiology, Methodist Hospital, Indianapolis 46207.

Supported in part by a grant from the American Cancer Society, Indiana Division, Inc.



A hospital for the diagnosis and treatment of psychiatric illness

WABASH VALLEY HOSPITAL

(a not for profit corporation)

2900 North River Road (State Road 43 north)

West Lafayette, Indiana, Phone 317-743-3841

Active Psychiatric Staff

W. R. VanDenBosch, M.D.

David L. Evans, M.D.

Joe M. Martin, M.D.

Edgar C. Stuntz, M.D.

J. Kenneth Cooke, M.D.

Limited private practice

John H. Wilms, M.D.

F. H. Spurlock, M.D.

Alfred R. Heasty, M.D.

(Phone)

447-6404

447-9155

743-1809

92-2441

Robert K. Jones, Ph.D.

Clinical Psychologist

Mrs. Margaret Keedy, A.C.S.W.

Psychiatric Social Worker

Elizabeth J. Snyder, R.N.

Director of Nursing Service

James Jones, B.P.E.

Director of Activity Therapy

Donald R. Kinzer, Hospital Administrator

Admissions are arranged through referral to any active staff psychiatrist.

All general medical and surgical specialties in the community are available through physicians on the open consulting staff.

Devoted to the interests of the medical profession of Indiana

Editor: Frank B. Ramsey, M.D., 1802 North Illinois Street,
Indianapolis, Ind. 46202.

Associate Editors: A. W. Covins, M.D., 221 South Sixth
Street, Terre Haute; Loll G. Montgomery, M.D.,
Ball Memorial Hospital, Muncie; David A. Bickel,
M.D., 515 Odd Fellows Building, South Bend,
Samuel R. Mercer, M.D., 702 Medical Center Bldg.,
Fort Wayne; I. W. Wilkens, M.D., 1743 Shelby St.,
Indianapolis.

Editorial Board:

Term Expires

Harold D. Lynch, M.D., Evansville	Dec. 31, 1967
Jene R. Bennett, M.D., South Bend	Dec. 31, 1967
Alvin J. Holey, M.D., Fort Wayne	Dec. 31, 1968
Wei-Ping Loh, M.D., Gory	Dec. 31, 1968
Jack W. Hickmon, M.D., Indianapolis	Dec. 31, 1969
Frank H. Coble, M.D., Richmond	Dec. 31, 1969

Assistant Editor: Jackie Freers Stohl
Business Manager: James A. Waggener
3935 N. Meridian, Indianapolis, Indiana 46208.

Measles Eradication

THE effectiveness of measles vaccine is proven by the remarkable decline in the number of cases which have been reported this year. The Communicable Disease Center of the U. S. Public Health Service estimates that the incidence of the disease is now less than 13% of what it was before the use of vaccine.

The fact that the vaccine has been put to considerably less than universal use and has achieved such a record would indicate that it is effective enough to absolutely eradicate the disease, if its use becomes widespread.

Dr. A. L. Marshall, Jr., Director of the Division of Communicable Disease Control of the State Board of Health reports elsewhere in this issue of *The Journal* (p. 1691) on the progress of measles eradication in Indiana. We have made a good start and need only to complete the immunization campaign as quickly as possible in order to make measles an extinct entity.

As long as there was no specific cure for measles and as long as it could not be prevented, it was all-right for everyone to say that it was just "a childhood disease" and infer that it was harmless. As a matter of fact it is not harmless, far from it.

Now that it can be prevented, it is wrong not to eliminate it and it is also wrong to infer that the disease is innocuous.

"Not the Name by Which it is Sold"

MR. Henry F. DeBoest, vice-president for corporate affairs for Eli Lilly and Company, came away from his testimony before Senator Gaylord Nelson's subcommittee with praise both from the committee chairman and from Senator Mark Hatfield. In his four-hour appearance before the Monopoly Subcommittee of the Senate Select Committee on Small Business, Mr. DeBoest not only presented several significant exhibits but also contributed facts and well-supported opinions which undoubtedly added to the mass of constructive reasoning the committee is seeking to produce.

Mr. DeBoest's testimony was reported, in addition to the highly instructive exhibits, as varying from a well prepared written introduction to a lengthy question and answer form and then to dialogue with the senators, which, while it presented divergent views, was moderate in tone and avoided the verbal clashes sometimes heard in such circumstances.

Adjournment of the session included Senator Hatfield's comment "very excellent presentation" and Senator Nelson's statement that "You have added considerably to the value of the record."

Testimony in previous weeks by witnesses generally considered as antagonistic to the best interests of medicine had, among other things, sought to establish practicing physicians as a group of "general ignor-amuses" and to assign the pharmaceutical industry's total national promotional and distribution expenditures of around \$600 million as all due to advertising.

Mr. DeBoest was able to record his disagreement with the uncomplicated reference to practicing physicians and indeed praised them for their use of modern drugs as based on their knowledge and experience.

Criticism of the industry, which had accrued as a result of charges of over-advertising and over-promotion, was considerably counteracted by his showing that the most quoted figure included large costs for distribution and the remainder was quite modest when measured against the numbers of physicians and companies involved.

The underlying theme of previous

testimony has been the "high" price of drugs. Charts were introduced to illustrate the rise of 20 points in the cost of living as represented by the Consumer Price Index, and a decrease in the Lilly Price Index of 12.5 points during the same period, a record which has been approximated by the pharmaceutical industry at large.

The conversation, as would be expected, got around to the subject of brand name drugs versus generic drugs. This has been one of the main items of controversy in Senator Nelson's hearings as well as in the hearings before Senator Long's committee. Since Eli Lilly is well known for making brand name drugs of top quality and generic drugs of the same top quality, Mr. DeBoest could be expected to be a most instructive witness of this subject, and, in fact, proved to be.

He stated his company's position to be "that generic drugs which are known to be manufactured and marketed by a company with a reputation for competence, quality, and integrity are fully acceptable."

And that "Neither generic drugs nor trade-marked drugs are any better than the demonstrated reliability of their manufacturer; the important thing, from the standpoint of the physician and his patient, is not how the product is named, but how expertly it is made."

Mr. DeBoest also said: "This subcommittee has heard much testimony about generic drugs and trade-marked drugs. It will perform a valuable public service if it can explode the myth that drugs prescribed by

generic name are always inexpensive and drugs prescribed by trade-marked name are always expensive. This is just not true."

Perhaps his best point was made when he expressed the hope that "despite the testimony of some witnesses who have appeared in these hearings, members of this subcommittee realize that it is the safety and effectiveness of a drug product and the total contribution of its manufacturer in terms of research, manufacturing excellence, and service that determines the product's price—and not the name by which it is known and sold."

Guest Editorials

Thoughts on an Old Problem

ALTHOUGH some of our academic and psychiatric colleagues believe that we overemphasize the importance of narcotic addiction among physicians, it has long been the most pressing disciplinary problem. It has been estimated that one out of every 100 doctors is an addict;¹ granted that this is only one percent but it does not include the much larger number who have at some time had difficulty with narcotics followed by satisfactory rehabilitation. Narcotic addiction is 30 to 100 times more prevalent in physicians than in the general population. Undeniably it is an occupational hazard.

Despite the importance of the problem, there is a dearth of thorough studies of addiction among physicians. Therefore a recent article by Charles H. Jones, M.D.² is a welcome addition. At the risk of oversimplification he faces the situation squarely and plainly labels the underlying psychiatric illness as depression.

He points out that it occurs at the same incidence in the United States, England, Germany, Holland and France. Fifteen percent of known drug addicts in all these countries are physicians. The age of onset of addiction in physicians is strikingly uniform. Says Jones, "Aside from depressive symptomatology and good results from depressive treatment regimens, such as electroshock therapy, a good case for a depressive etiology of narcotic addiction of physicians can be made by longitudinal studies of common personality traits and psychodynamic factors. These elements of depressive illness have been noted with great frequency in the life history of these patients." The proper approach: "Treat the depression as early as possible. Jones points to the successful efforts at rehabilitation carried out by boards of medical examiners. He approves of their benevolent attitudes and believes that because of their position of authority, they are most important in the coordinated planned efforts which are necessary in rehabilitation. His final plea: "Please, if the depressive symptomatology of addiction comes to your attention in a colleague, refer his case to the State Board of Medical Examiners so that responsible rehabilitation may be undertaken."

Of course, more important than treatment is prevention of addiction and this can be best brought about by more careful selection of medical students and also by education of both students and house officers in the proper handling of narcotics and in the perils of addiction.

That the Federation is constantly aware of the problem of addiction of physicians is exemplified by Resolu-

tion Number 1* presented by the Board of Examiners of the State of Oregon Rightly this resolution refers to the abuse of all dangerous drugs and urges the Federation to initiate "a comprehensive, nationwide program to inform physicians of the frequent occurrence and the dangers of habituation" to these drugs. It also recommends that the Federation enlist the aid of appropriate educational and professional associations in an educational program.

The Oregon resolution was approved. It is proper that the Federation exercise leadership in this important field and we assume that implementation of the resolution is al-

* Resolution 1. Presented by Board of Medical Examiners of the State of Oregon.

WHEREAS, The Federation of State Medical Boards of the United States recognizes that the excessive use of alcohol, the habituation to amphetamines, barbiturates and other drugs, and in addition to narcotics are frequent causes of disciplinary actions against licentiates by member boards of the Federation; and

WHEREAS, At the present time, there is no nationwide educational program specifically designed to emphasize the dangers of such excessive use, habituation or addiction in physicians; now, therefore, be it

RESOLVED, That the Federation of State Medical Boards of the United States initiate a comprehensive, nationwide program to inform physicians of the frequent occurrence and the dangers of the habituation to amphetamines, barbiturates and other drugs; danger of the excessive use of alcohol; the danger of narcotic addiction in physicians who use narcotics in self-medication. In the development of such a definite educational program, it is felt that the assistance of the American Medical Association and other professional associations and groups will be required; and further, be it

RESOLVED, That the Federation enlist the participation of appropriate educational and professional associations in a program to encourage professional schools and colleges, as well as hospitals and clinics, in their post-graduate educational program to emphasize to medical students, interns, residents and fellows, the danger of the excessive and frequent personal use of alcohol, barbiturates, amphetamines and other drugs, especially the danger of narcotic addiction in physicians who use narcotics for self-medication.

ready well under way.

REFERENCES

1. Fiorino, John M.: Narcotic Addiction in Physicians, *Fed. Bull.* 47:273-280, August, 1960.
 2. Jones, Charles H.: Narcotic Addiction of Physicians, *Northwest Med.* 66:559-567, June, 1967.
- Federation Bulletin*, Vol. 54, No. 9, Sept., 1967. Reprinted with permission.

Dr. E. S. Rifner, ISMA Ex-President

ON October 17th of last year, we editorialized on Van Buren's physician, Eugene S. Rifner, M.D., on the occasion of his ascension to the presidency of ISMA, the Indiana State Medical Association. Today, he steps down from the pedestal to which Hoosier physicians have looked up for guidance and inspiration in the political sphere of the medical world.

It is a privilege for us to say to Dr. Rifner: We thank you for the work you have done. We are proud of you as Grant County's outstanding physician in public life. You have brought honor to us. Now that you have tasted the blood of the political arena, you ought not to say, as you did, according to your interview with Ed Breen, the staff writer, printed in yesterday's *Leader-Tribune*: "Now I'm the late Dr. Rifner. I'm politically dead." On the contrary, we hope that you will say: "Now I'm the youngest ISMA ex-president. I'm not politically dead. I shall continue to fight for the physical and mental health of the human being."

We need the young, yet experienced leaders in medicine to explain the changes in our thinking, in our laws, in our ethical code necessitated by the gifts the biomedical profession is offering mankind. Our view is perhaps best expressed by Sir Julian Huxley's 1962 pronouncement: "In our psychosocial evolution, I believe, we now are in a position to make a new major advance, for instance in education. We can now educate people in the evolutionary concept and in the ecological concept . . .

which are now turning out to be very important ways of organizing our thinking about life and its environment. Indeed, there are many important new concepts (such as family planning, eugenics and euphenics, spare-part medicine, psychopharmacology and psychotechnology, all of) which we could bring out in a radically reorganized educational system."

The role of the learned physician of today and the future is to convey his knowledge—expressed in everyday terminology rather than in the orthodox medical jargon—to his colleagues and to the members of other professions for the purpose of bringing the social advances in step with those of the biomedical sciences. Bernard Russell once exclaimed: "Isn't it nice to know things!" Yet, we assert that it is nicer to teach others the things we know. Hopefully, this will be Dr. Rifner's task, as ISMA ex-president, and may it bring him fulfillment.

The late geneticist, John Burdon Sanderson Haldane, told us: "I am fully convinced that the recipe for happiness is doing a job which is difficult, but not too difficult." May his words stimulate Dr. Rifner to continue his participation in man's effort for the benefit of all mankind. —**Editorial, Radio Station WMRI, Marion, Ind. Reprinted with permission.**

Mathematics Teachers and Others

THE old grouch related that not too many years ago in this state there appeared to be a shortage of teachers of mathematics, particularly at the high school level. Those who viewed this situation with alarm were also aware of the relative lack of status enjoyed by mathematics teachers. At that time, teachers of mathematics were considered to be "Former engineering students who couldn't make the grade."

The ivory tower approach to cor-

recting these difficulties was straightforward; "we will change the training and licensure requirements to build a new type of mathematics teacher who will be better prepared and who will therefore enjoy higher status." This policy has been followed so that prospective mathematics teachers are required to have a greater number of course hours in new math, grade requirements have been increased and work must be started on one's Masters Degree in a shorter time after receiving the A.B. Degree.

Many young men faced with the prospect of increased graduation and licensing requirements or the choice of pursuing a very similar or perhaps only slightly longer training period to enter industry with its higher pay, better benefits, etc., chose the latter.

The result: fewer mathematics teachers.

We now have a shortage of general practitioners. Their status is said to be wanting.

Many advise creation of general practice residencies, thus prolonging the training period.

Many advise a specialty board examination to improve competence and elevate status.

The old grouch stalked away—
J. W. H.

Editorial Notes...

More private health insurance dollars go to families in the country's East North Central region—consisting of Ohio, Indiana, Illinois, Michigan and Wisconsin—that to families in any other region in the nation, as reported by *Health Insurance News*. The rating by states places New York first and California second. Alaska is No. 50.

The Atomic Energy Commission and the U. S. Navy have developed a radioisotope-powered heating system for divers. The inner garment is in the nature of "long-johns" with tiny plastic tubes

which circulate hot water in all directions. The heater is ten inches long and four inches in diameter and contains four capsules of plutonium-238 fuel. Radiation from the fuel is negligible. The initial model is effective down to a water temperature of 45 F., but suits can be built for colder environment. The device may be adapted for use by pilots, astronauts and Arctic researchers.

Major medical expense insurance has been the fastest growing type of medical insurance since it became generally available in the early 1950's. About 55.5 million Americans under the age of 65 are protected by major medical. In addition, there are about 1.1 million persons 65 and over, who are eligible for medicare, but carry major medical.

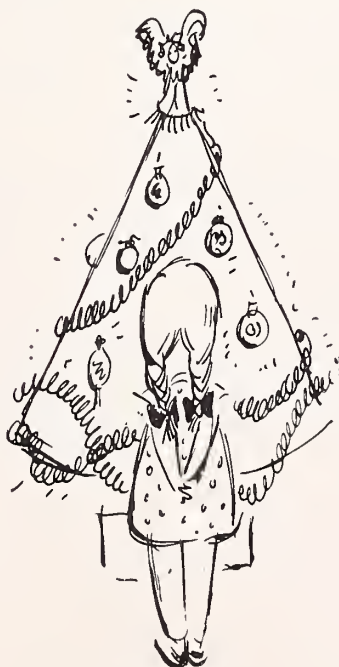
The 3M Company has published a reference book designed to provide an educational curriculum for the first 12 grades which will lead to the first comprehensive health education program in U. S. schools. It is the result of an intensive six-year study

by a national independent group of recognized authorities in medicine, health and education. Further details on "Health Education, A Conceptual Approach to Curriculum Design" may be obtained by writing Richard A. Joyce, 2501 Hudson Road, St. Paul, Minnesota 55119.

The American Association of Blood Banks has received a grant of \$633,044 from the Public Health Service for a five-year nationwide series of workshops on blood and blood component therapy. The technics to be studied provide more specific therapy which is less hazardous to the patient and more economical in the utilization of blood. The use of packed red cells, platelet transfusions, white-cell-poor blood for leukemia, expanded plasma programs to provide components such as AHG, albumin fibrogen, gamma globulin and other derivatives will be discussed.

The Atomic Energy Commission and the state of Washington are conducting a six-month trial program with a mobile food irradiation device. The truck-mounted kit contains a sealed source of 170,000 curies of cesium-137 which can process from 200 to 300 pounds of product per hour. Radiation pasteurization of vegetables and fruits requires relatively low doses to retard the growth of micro-organisms, thus delaying spoilage. No radioactivity is imparted to the food.

Vincristine sulfate is reported as an important addition to the treatment of Wilms' tumor. The October 30th issue of *JAMA* contained an article by four Houston physicians who gave the drug in lieu of preoperative radiation. The tumors in each of four children decreased markedly in size and were removed surgically. All four patients are doing well five to 21 months after operation.



Meet The Journal Staff



Dr. Alvin J. Haley of Fort Wayne was elected to the Editorial Board of *The Journal* in 1963 and has been an actively working member of the board ever since. He obtained his medical education at Indiana University, was granted a B.S. degree in Anatomy and Physiology in 1950 and attained the M.D. degree from Indiana University School of Medicine in 1953.

After internship at the Lutheran Hospital, Fort Wayne, he entered the general practice of medicine and has practiced as a family physician in Fort Wayne since 1954.

Dr. Haley is an active member and has been president of the Parkview Memorial Hospital medical staff. He is also an active member and has been treasurer of the Lutheran Hospital medical staff. He is on the courtesy staff of St. Joseph's Hospital.

Dr. Haley is currently the president of the Fort Wayne (Allen County) Medical Society. He is also a vice-president and former director of the Indiana Academy of General Practice.



Dr. Irvin W. Wilkens of Indianapolis served on the Editorial Board from 1955 to 1967 and was elected as an Associate Editor in 1967.

Dr. Wilkens is a native of Indianapolis and was graduated from Manual Training High School prior to attending Indiana University. He was awarded the B.S. degree in 1926 and the M.D. degree in 1929.

His postgraduate training consisted of a rotating internship at the Methodist Hospital in Indianapolis and a residency in medicine at the same hospital. Following this he had a fellowship at the E. P. Joslin Clinic in Boston.

Dr. Wilkens specializes in internal medicine with special interest in the treatment of diabetes. He is a member of the medical staffs of the Methodist, Community, St. Vincent's, St. Francis, University Heights and Marion County General Hospitals and is a member of the Board of Trustees of Community Hospital.

He served as president of the Marion County Medical Society in 1959 and was treasurer of the Indiana State Medical Association for three years, from 1961 to 1964.

Dr. Wilkens is a member of the American Society of Internal Medicine, and of the Indianapolis and American Diabetes Association. He is proud to be an Honorary Colonel of the State of Kentucky.

He is an associate instructor in medicine at Indiana University School of Medicine and serves as clinical instructor at Marion County General Hospital.

DORSEY "FLU-GRAM"

DON'T BE LULLED BY RELATIVE LACK OF FLU LAST WINTER. THIS
WINTER BE PREPARED: WHEN THE COMPLAINTS ARE COUGH AND
CONGESTION, YOU CAN RELIEVE THESE SYMPTOMS WITH TUSSAGESIC
TABLETS. ONE TIMED-RELEASE TABLET AT MORNING, MIDAFTERNOON
AND BEDTIME BRINGS UP TO 24 HOURS' RELIEF FROM TROUBLESOME
COUGH AND STUFFED AND RUNNY NOSE. TUSSAGESIC IS THE FAMOUS
TRIAMINIC FORMULA, PLUS THREE OTHER PROVED CONSTITUENTS.
MAKES PATIENTS MORE COMFORTABLE. FAST. ASK YOUR DORSEY
REPRESENTATIVE FOR SUPPLY OF STARTER SAMPLES, OR IF FLU IS
ALREADY EPIDEMIC, PHONE COLLECT. SEE BELOW.

each **Tussagesic®**

timed-release tablet contains:

Triaminic® 50 mg.
(phenylpropanolamine hydrochloride 25 mg., pheniramine
maleate 12.5 mg., pyrilamine maleate 12.5 mg.)
Dextromethorphan hydrobromide 30 mg.
Terpin hydrate 180 mg.
Acetaminophen 325 mg.

Dosage: Adults—1 tablet, swallowed whole to preserve timed-release feature, in morning, midafternoon and at bedtime. Side effects: Occasional drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: The patient should be advised not to drive a car or operate dangerous machinery if drowsiness occurs. Use with caution in patients with hypertension, heart disease, diabetes or thyrotoxicosis.

DORSEY LABORATORIES
a division of The Wander Company
Lincoln, Nebraska 68501

clip and file under "flu"

For relief of "flu-like" symptoms
Tussagesic timed-release tablets

PHONE COLLECT

For emergency starter samples
to Keith Sehnert, M.D.
Medical Director
(402) 434-6311

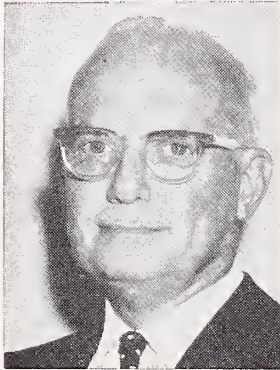
Fast delivery by your Dorsey
Representative

President's Page

Dear Doctor:

This month's President's Page will concern itself with two items, each timely as the Holiday Season and the New Year approach.

The first item is brought to mind inasmuch as the first of the year brings with it the obligation to pay our annual dues. This year for the first time the House of Delegates of the Indiana State Medical Association has authorized the inclusion



of a 50 dollar *voluntary non-tax deductible* contribution to IMPAC and AMPAC, the political action committees of the ISMA and the AMA, with the statement for our county, district, state and AMA dues. Admittedly there have been mistakes made in the past in these programs. There will be other mistakes made in the future. However, taken as a whole, our efforts have been amazingly successful! May I ask you, each of you, personally, to have faith in the officers of your PAC organizations, to believe in their ability, their knowledge, and their wisdom, and to demonstrate this faith and this belief by cooperating 100%!

It seems to me we can do no less in the interest of passing on to our children the freedoms each of us has inherited from our forefathers.

The second one is indeed a pleasant one. On behalf of each of the officers of ISMA and of each of the members of the headquarters staff may I express to you and yours sincere wishes for a Merry Christmas and a Happy New Year. It seems appropriate to share with you the thoughts expressed in one of my most treasured possessions—a motto, hand painted and framed, which hangs on the wall in my office. It was written by my mother and given to me as a Christmas present the first Christmas I was in practice. It reads as follows:

Give me, O Lord, the power
To see, to know, to feel—
And not for sake of gain
Or love of fame
Ask I this boon.
Give me, O Lord, the power
To heal—
That I may serve humanity
And Thee.

G. O. Larson M.D.



after surgery

B and C vitamins are therapy: Therapeutic amounts of B and C in stress formula vitamins often are vital during periods of physiologic stress. STRESSCAPS capsules, designed to meet increased metabolic demands, aid in achieving a more comfortable convalescence, a more rapid recovery. After surgery, as in many stress conditions, STRESSCAPS vitamins are therapy.



Stresscaps[®]

Stress Formula Vitamins Lederle



Each capsule contains:
 Vitamin B₁ (Thiamine Mononitrate) 10 mg
 Vitamin B₂ (Riboflavin) 10 mg
 Vitamin B₆ (Pyridoxine HCl) 2 mg
 Vitamin B₁₂ Crystalline 4 mcgm
 Vitamin C (Ascorbic Acid) 300 mg
 Niacinamide 100 mg
 Calcium Pantothenate 20 mg
 Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

Lederle

627-6-3613

When the agitated geriatric disrupts the home...

His teen-age
granddaughter
won't invite
friends
home
because
of his
outbursts.



for moderate to severe anxiety

Mellaril[®]
(thioridazine)
25 mg. t.i.d.



**His slovenly room
and habits create
more tension.**

**His disturbances at
the table make every
meal a nightmare.**

**His daughter
can't please him.
There is "just no
living with him."**

See following page for prescribing information.

When the agitated geriatric disrupts the home...

Anxiety that *seriously interferes* with the individual's performance at work, at home, or in the community may be regarded as *moderate to severe* in degree.

Mellaril often recommends itself to the treatment of moderate to severe anxiety because it

- helps control the most frequent symptoms: marked tension, agitation, apprehension, restlessness, hypermotility
- often alleviates anxiety-induced somatic complaints
- frequently helps strengthen emotional resources
- helps the patient maintain realistic contact with environment, closer harmony with family

Thus, when you consider the anxiety moderate to severe... consider Mellaril.

Contraindications: Severely depressed or comatose states from any cause, and in association with or following MAO inhibitors; severe hypertensive or hypotensive heart disease.

Precautions: Hypersensitivity reactions (e.g., leukopenia, agranulocytosis) and convulsive seizures are infrequent. Pigmentary retinopathy has been observed where doses in excess of those recommended were used for long periods of time. May potentiate central nervous system depressants, atropine, and phosphorus insecticides. Where complete mental alertness is required, administer the drug cautiously and increase dosage gradually. In addition, orthostatic hypotension (especially in female patients) has been observed. Epinephrine should be avoided in treatment of drug-induced hypotension.

Side Effects: Pseudoparkinsonism and other extrapyramidal disorders are infrequent; drowsiness, especially in high doses early in treatment, may occur; nocturnal confusion, dryness of the mouth, nasal stuffiness, headache, peripheral edema, lactation, galactorrhea, and inhibition of ejaculation are noted on occasion; photosensitivity and other allergic skin reactions may occur but are extremely rare.

Before prescribing, see package insert for full product information.

for moderate to severe anxiety

Mellaril®
(thioridazine)
25 mg. t.i.d.



mudrane®

for

- EMPHYSEMA
- ASTHMA
- CHRONIC BRONCHITIS
- BRONCHIECTASIS

*The
fast-disintegrating
uncoated tablet
gives relief in
15 minutes*

Each tablet contains:

Potassium Iodide.....195 mg.
Aminophylline.....130 mg.
Phenobarbital, Caution: May be habit forming... 21 mg.
Ephedrine HCl..... 16 mg.

FEDERAL LAW PROHIBITS
DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop.

Iodide contraindications: tuberculosis, pregnancy.

DOSAGE

One tablet, with full glass of
water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

MUDRANE GG—Formula, dosage and package identical to Mudrane—*except*—100 mg. glyceryl guaiacolate replaces the potassium iodide. The value of Mudrane cannot be enjoyed by a small group in which K.I. is contraindicated. Mudrane GG is prepared for this group.

MUDRANE GG ELIXIR—Four 5 cc teaspoonfuls is equivalent to one Mudrane GG tablet. Dosage adjusted to age and weight of child. Mudrane GG Elixir is for pediatric patients and those who think they cannot swallow tablets. Dispensed in pint and half gallon bottles.

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856



The Woman's Auxiliary

REPORTS TO ISMA

Promoting health careers at the county level is one of the programs of the Woman's Auxiliary. In some areas of the state, the auxiliary is doing a superb job in recruiting. In other areas, the work consists of distributing health careers material to schools and libraries; in still other areas there is no activity in this field what-so-ever. Yet, as doctor's wives, we should place this high on our priority list. Lack of personnel in hospitals, nursing homes, laboratories and doctor's offices definitely hamper the efficiency of the physician in his practice of medicine.



Early in the year of 1967, a copy of "Opportunities Unlimited" was mailed to the office of every practicing physician in the state. Mrs. William Garner, Jr., our Health Careers chairman from New Albany, had the approval of the ISMA Executive Committee for this mailing. The agency responsible for this mailing was Indiana Health Careers, Inc. This mailing was done at no cost to the auxiliary or the ISMA.

The Woman's Auxiliary is a contributing member organization to Indiana Health Careers, Inc. We hope you have taken the time to examine the material and that you will urge your patients to consider paramedical careers. The field is wide; there is something for everyone. We at the state level are planning to take more leadership with the hope that we can create more interest throughout the state. We will need your help.

The holiday season is almost with us. All of the ladies in the auxiliary extend "Season's Greetings" to the men we appreciate so very much—our doctors.

Roberta P. Deever



JACK W. HICKMAN, M.D.
Indianapolis

Normal Sed Rate Higher in Elderly

It is extremely important in evaluating the results of any laboratory test to know the normal values for that test. It has been demonstrated in recent years that the normal range for glucose tolerance tests varies as the patient becomes older. A "positive" G.T.T. for a 25-year-old may very well be in "normal" range for a 75-year-old. A paper by Bottiger and Svedberg¹ shows that the same variation applies for the erythrocyte sedimentation rate. The authors present their data on 2,500 healthy men and women aged 20-70 to demonstrate a significant elevation of the E.S.R. in the older subjects. Their conclusion is that the upper normal for E.S.R. should be (in mm./hr.) below the age of 50: men 15, women 25 and above the age of 50: men 20, women 30.

Insulin Resistance Due to Antibodies Responds to Steroids

True cases of insulin resistant diabetes mellitus are seen quite infrequently in general medical practice. These cases present frustrating situations to even the most seasoned specialists. The personal experience of Oakley, Jones and Cunliffe with 28 new patients is therefore revealing.² They include 13 previously reported cases in their data. It is interesting that 29 patients were found to have insulin antibodies demonstrated by

passive cutaneous anaphylaxis. This gives further indirect evidence to the etiologic theory of an antigenic mechanism being responsible for the condition. Of practical clinical value was their finding that virtually all patients who demonstrated the antibodies had marked clinical improvement of diabetic control when treated with adrenal steroids. Although adrenal steroids have been advocated in the past, this new information gives a partial explanation of why some patients respond well and others do not.

High Blood Urea Decreases Erythrocyte Longevity

A number of mechanisms are responsible for the anemia that occurs in patients with chronic renal insufficiency. One of these mechanisms is elucidated by Shaw in a well-prepared paper.³ He was able to show that significantly reduced red cell survival was present in the 26 patients studied. It appears as though this is dependent on the blood urea level rather than on the single basis of impaired renal function and that the accumulation of other dialyzable molecules in the plasma (from protein metabolism) is responsible for the decreased cell survival. This mechanism must be included along with simple cell loss and decreased erythropoietin production in the production of the anemia.

Arrhythmias Prognosticate Infarction Only in Those of Medium Severity

Stock et al. studied 200 patients following myocardial infarction to determine the incidence and significance of arrhythmias.⁴ As in other studies, they found a very high incidence (82%) of arrhythmias. Of these, some 40% were classified as "major arrhythmias." It was found, however, that in patients with "mild" infarctions, arrhythmias were not a major cause of increased mortality. Furthermore, in patients with "cardiogenic shock" the mortality rate was so high anyway, that the arrhythmias were not a critical factor influencing survival. Their greatest prognostic significance therefore appears to be in patients who are assessed to have moderate to severe coronary occlusions but who are not in "cardiogenic shock."

"Four-Quadrant Taps" Helpful in Acute Abdomens

"Four-quadrant taps" have been performed in many hospital emergency rooms in cases of blunt trauma to the abdomen for some time and have been found to be very helpful in many cases. Baker et al. confirms the diagnostic value of this test in reporting their results in 101 cases.⁵ They again stress the safety of the procedure if properly performed by experienced personnel. They found

80% positive results in cases of intraperitoneal hemorrhage and perforated viscus. They feel that this technic may even be preferable to radiologic diagnosis in cases of suspected hollow viscus perforation. The authors stress, as all previous investigators have done, that a negative paracentesis does *not* rule out the possibility of intra-abdominal disease.

REFERENCES

1. Bottiger, L. E., Svedberg, C. A.: Normal Erythrocyte Sedimentation Rate

and Age, *Brit. Med. J.* 2:85-87, No. 5544.

2. Oakley, W. G., Jones, Valerie E., Cunliffe, A. C.: Insulin Resistance, *Brit. Med. J.* 2:134-138, No. 5545.
3. Shaw, A. B.: Haemolysis in Chronic Renal Failure, *Brit. Med. J.* 2:213-216, No. 5546.
4. Stock, E., Goble, A., Sloman, G.: Assessment of Arrhythmias in Myocardial Infarction, *Brit. Med. J.* 2:719-723, No. 5554.
5. Baker, W. N. W., Mackie, D. B., Newcombe, J. F.: Diagnostic Paracentesis in the Acute Abdomen, *Brit. Med. J.* 3:146-149, No. 5558. ◀



INDIANA UNIVERSITY SCHOOL OF MEDICINE LIBRARY TELETYPE SERVICE

Physicians in over 140 Indiana communities outside of Marion County who do not have direct access to the library may request specific references or bibliographic searches from the Indiana University School of Medicine Library by merely calling their local public libraries and asking that the request be placed by TWX. There is no charge for the teletype call.

Xeroxed copies of the first 20 pages of any one article are gratis. If an article is over 20 pages, a ten cent charge is made for each additional exposure.

For further information write to: Indiana University, School of Medicine Library, Reference Department, 1100 W. Michigan St., Indianapolis, Indiana 46207.

★
Specialized Service

IN
PROFESSIONAL LIABILITY INSURANCE

is a high mark of distinction

MEDICAL PROTECTIVE COMPANY
FORT WAYNE, INDIANA

Professional Protection Exclusively since 1899

INDIANAPOLIS OFFICE:

Kenneth W. Moeller, Representative

665 East 61st Street

Telephone: 317-255-6525

Mailing Address: P.O. Box 20132, Indianapolis 46220

If it doesn't work in a week, forget it.

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently. Large doses of Butazolidin alka are contraindicated in glaucoma.

Warning: If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with great caution in the first trimester of pregnancy.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and re-

port immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools or other evidence of intestinal hemorrhage occur. Make regular blood counts. Discontinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The most common are nausea, edema and drug rash. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately before or after meals or with milk to minimize gastric upset. Mild drug rashes frequently subside with reduction of dosage. However, rash accompanied by fever or other systemic reactions usually requires withholding medication. Purpuric rash has also been reported. Agranulocytosis, ex-

In rheumatoid arthritis, Butazolidin alka needs only a week's trial. If it doesn't work in a week, forget it.

A short trial period may spare patients weeks of discomfort. That's one reason why Butazolidin alka seems a good choice when aspirin fails.

It's not for every patient. Check carefully the Contraindications, Warning, and Precautions shown below.

And adverse reactions may occur. The most common are nausea, edema and rash. Rarely, agranulocytosis has been reported. All adverse reactions are listed below, too.

You'll know quickly if it works.
And most of the time, it will.



foliative dermatitis, Stevens-Johnson syndrome, or a generalized allergic reaction similar to serum sickness may occur and require permanent withdrawal of medication. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.

Dosage in Rheumatoid Arthritis: Initial: 3 to 6 capsules or tablets daily in 3 or 4 equal doses. Trial period: 1 week. Maintenance dosage should not exceed 4 capsules or tablets daily; response is often achieved with 1 or 2 capsules or tablets daily. 6509-V(B)R2

For complete details, please see full prescribing information.

Butazolidin® alka

Capsules: phenylbutazone, 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate, 150 mg.; homatropine methylbromide, 1.25 mg.

Also available: Butazolidin®, phenylbutazone; Tablets of 100 mg.



Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York

EU-5412S

For Winter Fun and Fitness: Curling

THOMAS N. DAVIS, III, M.D.
Hammond

HERE is increasing emphasis by the medical profession on the importance of regular physical activity as preventive medicine. Many physicians not only recommend exercises and sports for physical fitness but prescribe them as treatment. My article in the August, 1966 issue of *The Journal of the Indiana State Medical Association* on "The Ideal Sport for Emotional Health: Lawn Bowls" described a fascinating participant sport which for centuries has been considered beneficial to health and longevity. The purpose of this paper is to inform about another, somewhat similar sport, curling, which is played in winter on ice. It is very popular in certain northern countries, especially Canada, where it is even more popular than golf and hockey.

Curling is a kind of shuffleboard played on ice. No skates are used. Special 42 pound granite stones with handles are slid to the target at the other end of the "sheet" of ice, which is about 140 feet long. Although 42 pounds is not a light weight, delivery of a curling stone seems almost effortless once a player learns a proper delivery and is used to being on ice. It is always played as a team game with four players per team, each player having two "rocks." And so, each "end" played consists of 16 stones delivered by eight players. The direction of play alternates back and forth after each end. A game usually lasts 10 or 12 ends or about two and a half hours.

Object of the Game

The object of the game is to score points by delivering stones closer to the "tee" than the opponents. The tee is the center of a circle of 12

feet diameter called the "house." Only stones within or touching this circle are eligible to score. In principle, scoring is quite simple and is similar to that in horseshoes and lawn bowls. One point is scored for each rock closer to the target than the opponents' nearest one. In theory, as many as eight points can be scored in one end, but such an occurrence is rarer than a golfer's hole in one. Usually, only one or two points are scored, sometimes none at all.

A good delivery involves control of both distance and direction of the stone. But it is not as simple as it sounds, for several variables affect both of these elements. The ice, for instance, can be "fast" or "slow" depending upon how frozen it is and how smooth and level the surface. The "speed" of the ice often changes during the course of a match.

But one of the most interesting and challenging features of curling is that a stone tends to deviate to one side with a swinging or curving motion. This is what gives curling its name. A stone going 130 feet may deviate

several feet to either side. The principal cause of this lateral movement is a revolving motion imparted to the stone when it is delivered. It is almost impossible to deliver a stone without any spin. A clockwise spin is called an "in-turn"; and counter-clockwise an "out-turn." But if the rock is delivered with sufficient force, it will go straight the entire distance of the sheet of ice before curving.

A variety of shots are in the armamentarium of a curling team—in-turns, out-turns, guards and others. A "raise" is the improvement of a stone's position on the ice by nudging it with a subsequent one. A "wick" is the caroming of a stone off the side of another one as in a billiard game. It is relatively easy to get a stone near the target—but keeping it there against a skilled team is another matter. The play alternates between the two teams, the first player of Team A delivering the first stone, and the first player of Team B the next stone. Then A's second stone. Then B's. And so forth.

MRS. DAR CURTIS delivers a 42 lb. granite on a "sheet" of ice.



The last player on each team to deliver his stones, the "skip," is in charge of his team's strategy. In fact, the two skips are in charge of the entire match. The ideal skip is highly skilled at shot making and strategy and he is able to assess the peculiarities of the sheet of ice. He recognizes and takes into account the strengths and weaknesses of the players—both teammates and opponents. Most of all, he is a leader who communicates clearly and who inspires his team.

"Sweeping the Ice"

One of the most striking features of curling is that the sheet of ice is swept with brooms in front of the moving stones. This custom makes curling a truly colorful and unique sport. Why is it done? The reason is simple—to make the stone go further when it is delivered too lightly. The sweeping in curling is about as old as the sport itself—at least four and a half centuries. To ardent curlers, the sport would not be curling if there were no sweeping. Many claim that good sweeping makes a stone go as much as 15 additional feet! And machine testing has shown that it can, indeed, make a difference of at least five or six feet on level ice.

Why does sweeping add distance to the stone's travel? First, it cleans away any debris and frosting that would impede the rock's movement. But more than that, sweeping is supposed to melt the ice a bit and thus provide some lubrication. Of course the sweeping has to be vigorous and forceful to make a difference in this respect. It should also be done rhythmically and as close to the stone as possible—just in front of it but without touching it. Whether or not any melting actually does occur, a polishing effect of the ice probably does take place. Still another reason, at least in theory, is that rapid sweeping causes a partial vacuum which helps pull the stone along.

But regardless of the actual value in adding distance to the stone's

THE STONE has come near the "tee." The opposing "skip" sweeps its path hoping it will go "through the house."



journey, sweeping is an important element of curling, for it is great exercise and is emotionally satisfying. I have seen teen-agers sweep in a cadence rivaling dancing for rhythm, harmony and exhilaration. And the sound that can result from sweeping the ice vigorously with a special broom can rival that emanating from a teen-ager's guitar!

The sweeping helps to make curling a team game par excellence. When to sweep and when not to? Split second decisions have to be made. It's up to the skip to command "Sweep" and "Brooms Up" according to his judgment. Every curler has his broom handy. The skip, when not delivering his stones, stands near the tee and holds his broom upright as an aiming sight for the player delivering the stone. And the player delivering holds his broom in his left hand to counter-balance the stone in his right hand. At the same time the other two players on the team stand poised ready to sweep at their skip's command. It is a real pleasure to watch two skilled sweepers performing harmoniously and enthusiastically. Even though only one player delivers a stone at a time, his three teammates are occupied at the same time in team play with the skipping and the sweeping.

The Slide Delivery

Another colorful feature of curling is the slide delivery. In this the player gets down very low and holds onto the stone during his follow-through

instead of releasing it promptly. The result is that his body slides along on the ice with the stone as far as 33 feet! Indeed, the longest slide on record is the whole length of the ice sheet—126 feet to the tee! A Canadian school boy did this feat, and as a result, a rule was made limiting the length of sliding permitted. The slide is very popular with younger players, and it is claimed to increase accuracy. Yet it is not necessary to skilled play and many players do quite well without it. And so its value to skill is controversial, but there is no doubt that it adds to the color and fun of the sport.

Curling is a splendid means of winter exercise as well as fun. The exercise comes from the body bending in delivering the stones—with or without the slide—and from the walking back and forth after each end. And, most of all, from the sweeping. The degree of exercise put into sweeping can vary considerably—from none at all to really vigorous movements of the entire body. In fact, the brooms of champion players in top competitions may last no longer than two or three games because of breaking! And at the other extreme, the broom is used for support rather than action!

This adaptability to almost any graduation of active exercise makes curling a superb participant sport. It can be played by almost anyone from about 12 to 90 years. A truly lifetime sport! Octogenarians have learned to play. Almost the only absolute contraindication to curling is confine-



THE player has slid about six feet from the "hack" in delivering his stone at Ridgeland Skating and Curling Rink, Oak Park, Ill.

ment to bed. A prosthetic leg, for example, does not preclude playing. In fact, handicapped players not able to stand up can curl from a wheel chair. Some persons may be unable to enter into the sweeping, but almost everyone can safely deliver a stone once he has learned a well coordinated delivery and is used to being on ice. Usually, only one lesson from an expert suffices, for satisfactory deliveries.

The Curler, a magazine published in Toronto, recently had an article discussing the effect the sport has on the curler's body. The editors corresponded with a number of curling physicians in Canada and the U.S. The consensus was that the low tension and the rhythmic and continuous motion involved in delivering a stone doesn't strain the heart. On the other hand, the short burst of rather violent movement involved in sweeping can provoke a rather severe oxygen deficit. Some of the doctors recommend a conditioning program for curlers who are overweight, over 40 and sedentary. This should include pre-game warm ups, as well as pre-seasoning conditioning.

Of particular medical interest is the "Coronary Curling Club," an international organization whose membership is limited to persons who have had a coronary attack but who curl. Dwight D. Eisenhower is an honorary life member. According to Lucius T. Hill of Boston, the founder and secretary, the majority of the members are pretty active curlers. But, he says,

vigorous sweeping is out. "Most of us just massage the ice gently." I have read of Canadian coronary victims who curl with their physician's approval but who do not sweep.

A Healthy "Addict"

Accidents and injuries are very rare in curling, especially with players who have been properly instructed. Mr. Dar Curtis of Winnetka, Illinois, has taught the game to over 2,300 players and has never encountered a serious accident among his pupils. The most serious accident he has seen on the ice happened not to a curler but to a spectator! (He fell and incurred a head injury.) Curtis emphasizes the importance of proper instruction to beginners.

An editorial in the April 1967 issue of *Massachusetts Physician* entitled "For Arteries and Fun" recommends curling as a good conditioning game which can be played all through the winter season, a game which can restore a satisfactory blood flow through constricting arteries. The editorial describes the rudiments of curling and then mentions that one of the pleasant aspects of it is that the novice gets as much pleasure as the expert. It is a game whose fundamentals are easily learned, though its strategy may take years. It concludes that "one of the dangers of the game is the possibility, even the probability, of becoming an addict, but the addict will be a healthy one."

Of course the value of any sport is directly related to the fun that it

affords. And curling is unsurpassed in this respect. Most of the features which make it fun are also enjoyed in lawn bowls, which I have written about previously. These include the challenge of mastering the canny neuromuscular skill needed to control both the distance and direction of an object that doesn't move in a straight line. And the competition. And the give and take between the two teams—the strategy. And, especially, the team play. (Nothing is more important to success than team harmony; individual performance is secondary.) The strong traditions of sportsmanship, camaraderie and amateurism all contribute to making curling a magnificent participant sport.

An Ancient Sport

Curling is such an ancient sport that its origin is obscure. There is some evidence that it may have started in Holland, but it has long been closely associated with Scotland, which has always supplied most of the world's curling stones. A curling stone was dredged from a lake bottom there bearing the date 1511. Until recently it has been almost exclusively an outdoor game there and in other European countries.

The first recorded curling club in North America, in Montreal, was organized by Scottish settlers and has been in operation since 1807. It has become the most popular sport in Canada, where there are more than half a million registered male curlers. Its tremendous growth in Canada is due in part to the installation of artificial ice not subject to the vagaries of the weather. Its greatest growth has occurred since World War II. The Canadian interest in it is the equivalent of our "Hoosier hysteria" about basketball. Curling is not considered a spectator sport, yet over 54,000 spectators watched recent Canadian Championships held in a stadium. It is taught to high school students there as basketball is taught here. It has been said that the annual

Canadian Curling Championship has helped to unite Canada in a manner that has never been achieved through politics or economics.

World Curling Championships for "The Scotch Cup" have been played annually since 1959. Canada has won it every year to date but two—the U.S. in '65 and Scotland in '67.

Curling is played in most northern states in the U. S. having been brought here by Scots and Canadians. Milwaukee Curling Club, founded in 1845, is the oldest in the U. S. The latest available statistics are—over 12,500 male curlers and over 120 clubs in 26 states. There are more clubs in Wisconsin than in any other state. The only curling in Indiana, to my knowledge, is the Elcona Curling Club of Elkhart, founded several years ago. Most of the growth of curling in the U. S. has been in recent years. For example, the number of curlers in the Chicago area has increased in the last three decades from 40 to more than 4,000! Much of this rapid growth has been catalyzed by the energy of Dar Curtis, who has helped more than 25 clubs to organize, and whose love of spreading the game has made him active in its behalf as far as Europe and Japan.

The Park district of Oak Park, Illinois, introduced curling to its

recreation program this past season. This is the first time the sport has been available to the public in the Midwest, if not in the U.S., and not limited to private clubs. A few hours per week in the use of a skating rink were set aside for curling. A charge of \$2.00 per player per game was made. The response was immediate. Within a few weeks there were many more would be curlers than could be accommodated. The park officials had had doubts about the project, but it proved such a success that they have made plans to build a rink exclusively for curling.

Bowling Green State University in Ohio began the sport late last winter, the first time it has been a regular college sport in the U. S.

The latest venture in the sport is the Curtis Curling Center of Wilmette, Illinois, scheduled for opening in December, 1967. It is described as "an educational institution for the general public, a model for future curling facilities throughout the country. All prospective curlers are invited to visit this unique facility."

For more information about this fast growing winter participant sport, write to Dar Curtis, 21 Indian Hill Road, Winnetka, Illinois 60093. His booklet, *Curling . . . Fun for Everyone*, is full of useful facts about all

aspects of the sport. It costs 25 cents. Also, write to *Curling News*, 723 Milwaukee Ave., South Milwaukee, Wis. 53172.

Summary

The advantages of lawn bowls, which I have written about previously, are generally true also of curling. It provides healthful exercise—an important need in our physically inactive lives. It is emotionally satisfying—also important in this day of so much leisure. It is fun—both for people who need relief from responsibilities and for those who have time on their hands. And fun for men and women of almost all age groups—a true lifetime sport. And it makes a fine family sport. The challenge of mastering the skills needed, the variety of play and the strategy make it fascinating. It helps to relieve excessive aggressive tendencies, symbolically, by the striking of the opponents' stones. It is a team sport par excellence with strong traditions of sportsmanship, amateurism and camaraderie, as well as team play. All these features make curling a winter participant sport unsurpassed for enjoyment and healthful exercise. ◀

5246 Hohman Ave.

Hammond, Ind. 46320

INDIANA MEDICAL BUREAU

816 Hume Mansur Bldg.

634-5804

*A Licensed Employment Agency
Specializing in Medical Personnel*

Our 16th Year Of Service

Drug Stocks Ease*

COMMON STOCK prices of leading drug companies tended to be somewhat lower during the past month after the strength shown earlier in the year. The following tabulation prepared by Smith, Barney & Co. Incorporated shows from left to right recent closing

prices, the 1967 price range, the annual rate of growth in earnings per share since 1959, the indicated annual dividend rate based on recent payments, the current dividend yield, the percentage gain or loss in price of the shares during the past month and from the beginning of the year to September 20, 1967.

* Courtesy Carl Byoir & Associates, Inc., New York, N.Y.

Company		Closing or Bid Price as of 10/18/67	1967 Price Range	Annual Rate of E.P.S. Growth 59-66	Indic. Div.	Current Yield	Percent Price Change from Previous Month	Percent Price Change from 01/03/67
Abbott Laboratories		45¾	54-41	9.7%	\$1.00	2.19%	-11.6%	0.0%
Alcon Labs.*	Apr	45½	48-22	27.0	0.45	0.99	-4.2	104.5
American Home Prods.		55½	60-49	8.3	1.20	2.16	-3.7	36.6
Barnes-Hind*	Jun	38	43-22	47.7	0.0	0.0	-5.0	60.0
Baxter Laboratories		40½	47-20	14.5	0.16	0.40	-4.7	102.5
Bristol-Myers		80	83-53	19.6	1.05	1.31	1.1	49.2
Carter-Wallace A.	Mar	17¾	20-13	7.1	0.45	2.54	-1.4	35.2
Cutter Laboratories		46¾	56-28	17.6	0.44	0.94	-5.1	60.5
Johnson & Johnson		87⅞	95-55	13.4	0.85	0.98	-0.7	54.5
Eli Lilly*		102½	118-85	12.9	1.60	1.56	-10.7	17.5
Marion Labs.*	Jun	59	64-19	99.9	0.24	0.41	9.3	105.2
Mead Johnson		35⅞	38-23	-6.4	0.48	1.35	-2.4	48.4
Merck, Sharp & Dohme		86⅞	94-74	15.7	1.60	1.84	-5.2	15.4
Miles Laboratories		42	46-31	9.1	1.00	2.38	-4.0	30.2
Norwich Pharmacal		91	91-60	9.4	1.50	1.65	4.7	51.0
Parke-Davis		28¼	34-26	-2.3	1.40	4.96	-7.8	5.6
Charles Pfizer		77⅞	93-68	10.6	1.45	1.86	-8.8	14.1
Plough		100¼	100-60	14.4	1.00	1.00	11.7	63.7
Rich.-Merrell	Jun	93	103-66	9.1	1.30	1.40	-3.1	19.2
A. H. Robins*		63¾	70-43	21.5	0.70	1.10	-7.6	35.6
W. H. Rorer		49¼	56-35	29.2	1.10	2.23	-10.5	29.6
Schering		63¾	70-54	5.8	1.20	1.88	-5.9	16.4
G. D. Searle**		60⅞	61-38	22.6	1.30	2.15	1.5	58.9
Smith Kline & French		59⅞	65-49	9.2	2.00	3.35	-3.8	16.3
Sterling		44¾	53-39	8.9	0.90	2.01	-13.5	13.3
Syntex	Jul	83⅞	109-69	99.9	0.40	0.48	1.1	16.7
Upjohn		58⅞	70-54	7.8	1.60	2.72	-5.4	-10.8
Warner-Lambert		41⅞	55-37	8.6	1.00	2.40	-11.7	9.5
WEIGHTED INDUSTRY AVERAGE				14.0%		1.98%	-5.3%	28.3%
639 WEIGHTED COMPANY AVERAGE						3.15%	-2.2%	

FOOTNOTES

- (a) 1967 figure is actual earnings.
- (b) Excludes proposed acquisition of Calgon.
- (c) Growth rate actually exceeded 100%. Computer program to maximum 99.9%.
- (d) Excludes \$0.07 non-recurring loss.
- (e) Excludes proposed acquisition of Texize Chemicals.
- (f) Excludes proposed acquisition of Maybelline.



Diagnosis:

cystitis?
pyelonephritis?
pyelitis?
urethritis?
prostatitis?
in any case,
usually gram-negative*

Therapy:

two 500 mg. Caplets® q.i.d.
(initial adult dose)

Summary of prescribing information

Indications: Urinary tract infections in which gram-negative bacteria are predominant, particularly *Proteus*, *Escherichia coli*, *Aerobacter*, *Klebsiella*, and certain strains of *Pseudomonas*. Gram-positive bacteria are less sensitive to NegGram but favorable clinical results have been observed.

Warning: Use in Pregnancy. This drug is not recommended in the first trimester of pregnancy. However, it has been used in several patients during the last two trimesters without producing apparent ill effects in either mother or fetus.

Precautions: As with all new drugs, periodic blood and liver function tests are advisable during treatment longer than 1 or 2 weeks. **This drug should be used with caution in patients with liver disease, epilepsy, severe cerebral arteriosclerosis, or severe impairment of kidney function.** Because photosensitivity reactions have been reported in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a photosensitivity reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Should bacterial resistance develop or additional nonsensitive strains emerge, other effective antibacterial agents should be added to or substituted for NegGram.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents may give a false-positive reaction.

Adverse reactions: Mainly mild nausea, vomiting, and other gastrointestinal disturbances; less frequently, sleepiness, drowsiness, weakness, headache, dizziness and vertigo, and rarely cholestasis, paresthesia, thrombocytopenia, leukopenia, or hemolytic anemia in patients with a deficiency in activity of glucose-6-phosphate dehydrogenase. Itching, pruritus, rash, urticaria, mild eosinophilia, reversible photosensitivity reactions primarily involving exposed surfaces, and reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), occurred occasionally. Reversible increased intracranial pressure with bulging anterior fontanel, papilledema, and headache has been observed occasionally in infants and children. Toxic psychosis and brief convulsions (the latter generally in patients with possible predisposing factors, and both usually associated with excessive dosage) have been recorded in rare instances.

Dosage and administration: **Adults**—Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily (1 Caplet of 500 mg. four times daily). **Children**—According to age and weight: approximately 25 mg. per pound of body weight per day, administered in divided doses.

Note: The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.

How supplied:

For adults—Buff-colored, scored Caplets of 500 mg., conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1000.

For children—Caplets of 250 mg., available in bottles of 56 and 1000.

Before prescribing, please refer to complete prescribing information.

References: (1) Based on 23 clinical papers, 1512 cases. Bibliography on request. (2) Bush, I. M., Orkin, L. A., and Winter, J. W., in Sylvester, J. C.: Antimicrobial Agents and Chemotherapy—1964, Ann Arbor, American Society for Microbiology, 1965, p. 722.

NegGram®
Brand of
nalidixic acid
a specific anti-gram-negative

eradicates most urinary
tract infections...

- Low incidence of untoward effects; no fungal overgrowth, crystalluria, ototoxic or nephrotoxic effects have been observed.
- "Excellent" or "good" response reported in more than 2 out of 3 patients with either chronic or acute gram-negative infections.¹

*As many as 9 out of 10 urinary tract infections are now caused by gram-negative organisms: *E. coli*, *Klebsiella*, *Aerobacter*, *Proteus*, *Paracolon* or *Pseudomonas*²... However, infections of the urethra and prostate caused by non-gonococcal gram-negative organisms are believed to be less prevalent.

Winthrop

Winthrop Laboratories, New York, N. Y. 10016

News from Indiana University School of Medicine

An award to be presented to a student at the Indiana University School of Medicine who has demonstrated outstanding achievement in pharmacology will be named for Dr. K. K. Chen, professor of pharmacology.

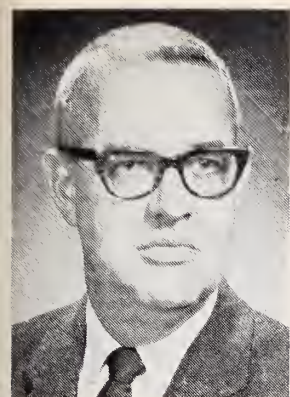
The K. K. Chen award, sponsored by Eli Lilly & Company, will carry an annual remuneration of \$100. Dr. Chen served as director of pharmacology research at the Lilly Company from 1929 through 1963.

Dr. Chen was born in China. He received his Ph.D.

degree from Wisconsin University in 1923 and his M.D. degree from Johns Hopkins University in 1927. He has been a visiting professor of pharmacology at the Indiana University School of Medicine from 1937 through 1962. Since 1963, he has been on the full-time faculty at Indiana University. Dr. Chen is a past-president of the American Society of Pharmacology and Experimental Therapeutics. He has served as consultant to many government agencies and is the author of more than 400 scientific publications and books.

VIDEOTAPE MACHINE INSTALLED—Dr. George T. Lukemeyer, associate dean of the Indiana University School of Medicine, center, discusses use of the videotape network being developed between the school of medicine and various community hospitals in the state, with Sister Delphine, director of the St. Vincent's Hospital School of Nursing, and Dr. Joseph C. Finneran, chief of the surgical section at the hospital. The equipment they are examining consists of a videotape recorder and color-compatible monitor just received and unpacked for the hospital's use. This equipment is being furnished by the school of medicine to participating institutions.






EDWIN E. PONTIUS, M.D.
Pathologist
Indianapolis
Chairman, Medical and
Scientific Committee

American Cancer Society Forms Speakers Bureau



CYRUS HOUSHMAND, M.D.
Surgeon
Bloomington
Chairman, Professional
Speakers Bureau



It is estimated that 8,100 Hoosiers will die of cancer in 1968 and 16,000 new cases will be discovered. A broadened application of present medical knowledge could prevent a large number of these deaths. Unfortunately, this knowledge is not being employed to its fullest potential in areas of public education, as well as in professional application. To aid in solving this problem, the American Cancer Society in Indiana is greatly

expanding its educational programs, through the work of its Medical & Scientific Committee and County Unit Professional Education Committees.

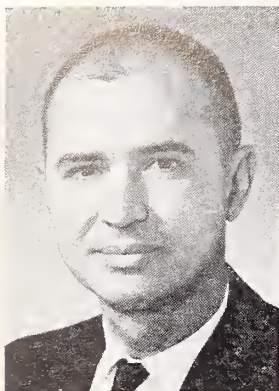
The society has formed a Professional Speakers Bureau of cancer specialists available to county medical societies, the Indiana Academy of

General Practice, hospital staffs and allied professional meetings. These speakers are prepared to discuss modern clinical methods of cancer detection, diagnosis and treatment; to encourage the use of such methods; and to report recent advances that research has contributed to the understanding of this disease. The speakers bureau includes medical and dental specialists, basic science researchers, public health experts, pharmacologists and nursing educators.

Other society sponsored activities for the continuing education of physicians include: Road Show scientific sessions and cancer conferences; scientific exhibits, and the publishing and distribution of professional journals, monographs and feature articles (including the "Cancer You View" and "Cancer Research Series" in *The Journal*.) Direct support of cancer research in Indiana has reached the two million dollar mark since 1945 (currently two hundred twenty-five thousand dollars in effect). Cooperation with educational groups, including the Indiana University School of Medicine and the Regional Medical Program on Heart, Cancer and Stroke, should result in complimentary activity.

The American Cancer Society has embarked on an extensive program of new cancer educational film production. Nine are now available: "Oral Cancer," "Nursing Management of the Patient with Cancer," "The Dentist and Cancer," "Cancer in Children," "Diagnosis and Management of Cancer of the Colon and Rectum," "Tumors of the Major Salivary Glands," "Cancer of the Stomach," "Early Diagnosis and Management of Breast Cancer" and "Cancer of the Skin." Eleven more are currently in production, three of which are scheduled for release by the end of 1967 ("Diagnosis and Management of Uterine Cancer," "Cancer of the Prostate" and "Hormonal Treatment of Cancer").

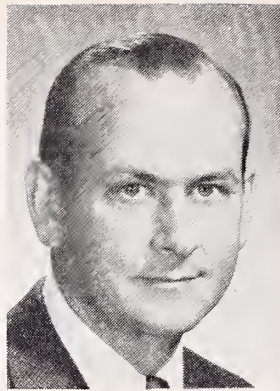
A complete list of speakers, including photographs and their specialty topics, are introduced on the following pages. Requests for the speaker of your choice should be made at least four weeks in advance of a scheduled meeting date and should be addressed to your local county unit of the American Cancer Society or the American Cancer Society Division office, 445 N. Pennsylvania St., Indianapolis.



MERRITT O. ALCORN, M.D.
Pathologist
Madison
"Cytology and Cervical
Cancer"



LAURENCE H. BATES, M.D.
Hematologist
Indianapolis
"Recent Advances in
Cancer Chemotherapy"



JAMES E. BENNETT, M.D.
Plastic Surgeon
Indianapolis
"Plastic Surgery and
Maxillofacial Cancer"



CHARLES BOONSTRA, M.D.
Pathologist
Bluffton
"New and Unproven
Methods of Cancer
Treatment"



**WILLIAM M.
CHRISTOPHERSON, M.D.**
Cyto-pathologist
Louisville, Ky.
"Cytology—Diagnosis of
Cancer"



EDGAR K. DeJEAN, D.D.S.
Oral Surgeon
Salem
"Oral Cytology—Technique,
Value and Limitations"



MAGDALENE FULLER, R.N.
Professor, Medical and
Surgical Nursing
Indianapolis
"Care of the
Colostomy Patient"



ROBERT A. GARRETT, M.D.
Urologist
Indianapolis
"Genitourinary Cancer"



DAVID M. GIBSON, M.D.
Professor of Biochemistry
Indianapolis
"Regulation of Cellular
Metabolism and Cancer
Pathogenesis"



MARTHA GODARE, R.N.
Nursing Instructor
Vincennes
"Nursing Management of
the Cancer Patient"



JAMES H. GOSMAN, M.D.
Dermatologist
Indianapolis
"Pre-cancerous and
Cancerous Lesions of
the Skin"



VICTOR C. HACKNEY, M.D.
Dermatologist
Indianapolis
"Dermatological Diagnosis
of Cancer"



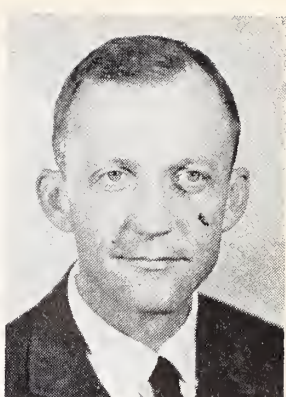
WESTON A. HEINRICH, M.D.
 Surgeon
 Evansville
 "Carcinoma of the
 Colon and Rectum"



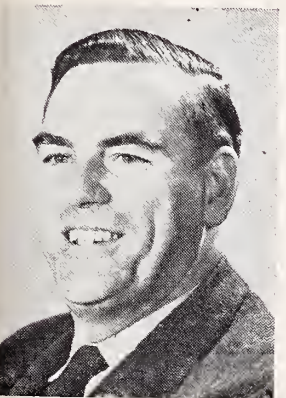
CHARLES E. HUTTON, D.D.S.
 Oral Surgeon
 Indianapolis
 "Tumors of the
 Oral Cavity"



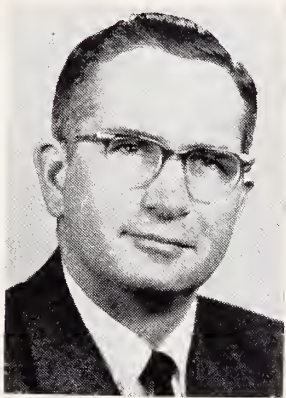
KARL L. KAUFMAN, Ph.D.
 Dean, Butler School
 of Pharmacy
 Indianapolis
 "Cancer Quackery"



HAROLD KING, M.D.
 Surgeon
 Indianapolis
 "Thoracic and Mediastinal
 Neoplasms"



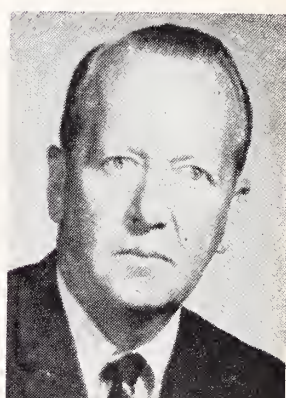
KINGSLEY LAWRENCE, M.D.
 Surgeon
 Indianapolis
 "Carcinoma of the Lung"



RALEIGH E. LINGEMAN, M.D.
 Otolaryngologist
 Indianapolis
 "Cancer of the Head
 and Neck"



GEORGE T. LUKEMEYER, M.D.
 Internal Medicine
 Indianapolis
 "Regional Program on
 Heart, Cancer and Stroke"



A. RICKS MADTSON, M.D.
 Surgeon
 Indianapolis
 "Surgical Management of
 Intra-abdominal Cancer"



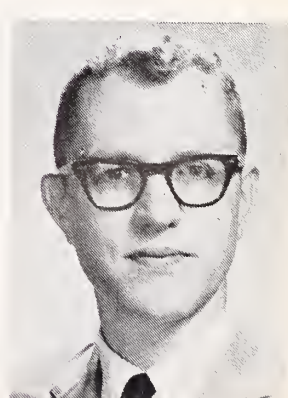
JOSEPH L. MORTON, M.D.
 Radiation Therapist
 Indianapolis
 "Radiation and Chemical
 Therapy of Cancer"



ARTHUR L. NORINS, M.D.
 Dermatologist
 Indianapolis
 "Dermatological Diagnosis
 of Cancer"



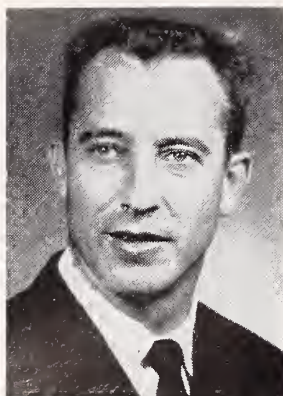
EILEEN PARKS, R.N.
 Nursing Instructor
 South Bend
 "What's New in Cancer
 Nursing?"



JOHN N. PITTMAN, M.D.
 Surgeon
 Indianapolis
 "Surgery Therapy of
 Lung Cancer"



CHARLES H. REDISH, D.D.S.
Oral Surgeon
Indianapolis
"Cancer of the
Oral Cavity"



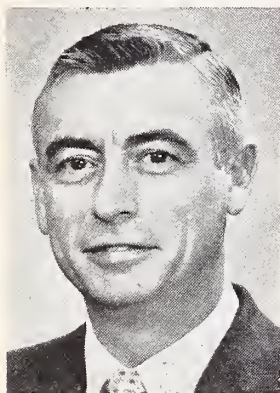
DONALD E. RHAMY, M.D.
Urologist
Indianapolis
"Carcinoma of the Bladder
and Ureter"



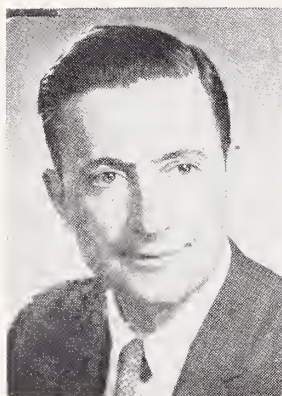
ROBERT J. ROHN, M.D.
Hematologist
Indianapolis
"Hematological Neoplasms"



MERRILL W. RUSHER, M.D.
OB-GYN
Bluffton
"Ovarian Carcinoma"



WILLIAM G. SHAFER, D.D.S.
Oral Pathologist
Indianapolis
"Pathology of
Oral Cancer"



HARRY SIDERYS, M.D.
Thoracic Surgeon
Indianapolis
"Tumors of the Chest
Wall and Sternum"



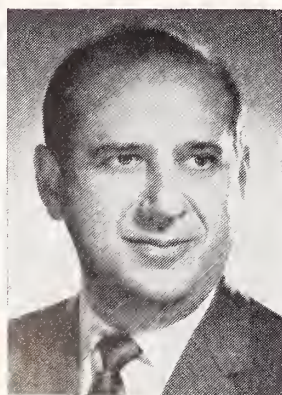
RICHARD A. SILVER, M.D.
Radiologist
Indianapolis
"Modern Usage of
Radiation Therapy"



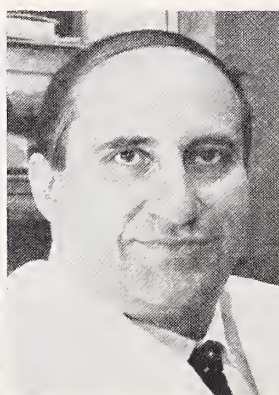
BURTON G. SMITH, D.D.S.
Oral Surgeon
Indianapolis
"Challenge of
Oral Cancer"



CHARLES R. THOMAS, M.D.
OB-GYN
Indianapolis
"The Challenge of
Genital Cancer"



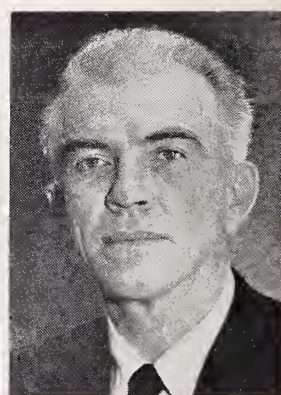
FRANK VELLIOS, M.D.
Pathologist
Indianapolis
"Diagnostic Problems in
Genitourinary Cancer"



GEORGE WEBER, M.D.
Professor of Pharmacology
Indianapolis
"Advances in Cancer
Research"



MELVIN WEINSWIG, Ph.D.
Professor of Medicinal
Chemistry
Indianapolis
"Pharmacology of Cancer
Chemotherapy"



ROBERT YOHO, H.S.D.
State Board of Health
Indianapolis
"Comprehensive Health
Care Planning: Cancer"

Status of Measles Eradication in Indiana

A. L. MARSHALL, Jr., M.D.
Indianapolis*

MEASLES (rubeola) immunization with attenuated virus vaccine has been proven effective. In November, 1965, the Indiana State Board of Health first made measles vaccine available to local health departments for the immunization of the indigent susceptibles in schools and well-baby clinics. In cooperation with the American Medical Association and the United States Public Health Service Plan to Eradicate Measles in 1967, both the Indiana State Medical Association and the Indiana State Board of Health endorsed a ten point plan for Indiana. This plan was endorsed by the Indiana Chapter of the American Academy of Pediatrics and the Indiana Health Officers Association. In addition, the 1967 Indiana General Assembly proposed a resolution to memorialize the Indiana State Medical Association and the Indiana State Board of Health to eradicate measles from Indiana.

In substance this plan provided for the Indiana State Board of Health to provide measles vaccine for all susceptible children between one and 12 years of age without charge to any local health department where the county medical society endorsed a measles immunization program. The decision as to type of program (i.e., whether vaccine would be given in schools, physician's offices, hospitals, etc.) and whether the physicians would donate their services or make a charge for administration, was left to the individual county societies. Records of children immunized were to be maintained in local health department offices. Under this plan it was

proposed that vaccine would be furnished until June 30, 1968. It is to be hoped that most counties will have had programs before January, 1968. In those counties with large numbers of non-immunized children where epidemics occur, vaccine will be furnished for epidemic use. With the widespread use of measles vaccine by private physicians in the last two years, the occurrence of two or more cases of measles in a community must be regarded as an indication of a focus of infection and a small localized epidemic can be predicted in the susceptible population.

Measles Incidence

Figure 1 shows the number of measles cases reported for the last five years. It is readily apparent that in Indiana peaks of reported cases have occurred in even numbered years. The uneven years indicate the periods when the reported cases are low. The low incidence in 1965 and 1967 below the year 1963 undoubtedly reflects some effect of vaccine, as does the lowering of the curve in 1966 which would have been

higher if it had followed the past pattern.

The year 1968, based upon past experience, should be an epidemic year in Indiana. The cases of measles reported in 1968 will reflect the influence of immunizations performed in 1967 and previous years.

Measles Surveillance

It has long been recognized that not all cases of rubeola are reported inasmuch as not all cases are seen by a physician. For this reason a letter was sent, with the approval of Richard D. Wells, Superintendent of Public Instruction, to all school principals and superintendents. The letter requested that absenteeism in schools due to measles be reported to the Indiana State Board of Health.

It is hoped that in schools where cases of measles are a cause of absenteeism, prompt steps will be taken by local medical societies and health departments to immunize all susceptible children in the community between ages one through 12. It has been amply demonstrated that measles immunization in the face of

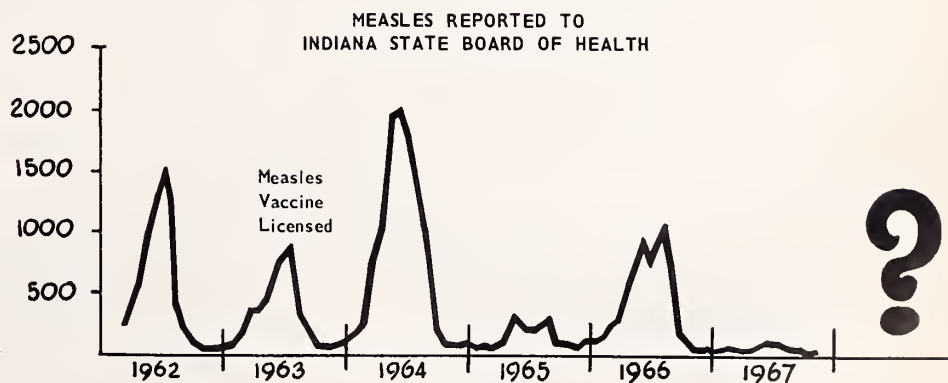


FIGURE 1
NUMBER of measles cases reported to the Indiana State Board of Health for the last five years.

* Director, Division of Communicable Disease Control, Indiana State Board of Health, Indianapolis 46206.

COUNTIES REQUESTING MEASLES VACCINE FOR MEASLES ERADICATION PROGRAM AS OF NOVEMBER 2, 1967

County	Vaccine given in:	Number Immunized	Doses Shipped	Status
Bartholomew	Central Clinic		2,410 (Estimated needs)	Pending
Benton	Physician's Offices	428		Completed
Boone	Physician's Offices		426	In Progress
Brown	Several Schools		350 (Estimated needs)	Pending
Carroll	Central Clinic	611		Completed
Clinton	Physician's Offices	940		
Crawford	Several Schools		400	
Decatur	Central Clinic		2,200	Nov. 5, 1967
Dubois	Planning Program			
Elkhart	Physician's Offices		3,036	In Progress
Floyd	Several School Sites	4,370		Completed
Fountain-Warren	Physician's Offices		1,100	In Progress
Grant	Central Clinic	1,254		Completed
Greene	Several School Sites	1,607		Completed
Hamilton	Central Clinics	600		Completed
Harrison	Central Clinic	416		Completed
Hendricks	Planning (By phone)			
Huntington	Physician's Offices		417	In Progress
Jasper	Hospital Clinic	1,008		Completed
Jennings	Central Clinic		1,000	Pending
Johnson	Physician's Offices			Pending
Knox	Central Clinic	1,600		Completed
Kosciusko	Physician's Offices		2,000	In Progress
LaPorte	Central Clinics	3,264		Completed
Marshall	Physician's Offices		750	In Progress
Monroe	Several School Sites	2,190		Completed
Montgomery	Several School Sites	2,121		Completed
Morgan	Physician's Offices		480	In Progress
Owen	School Sites	331		Completed
Parke	Central Clinic	521		Completed
Pike	School Sites		1,000	Dec., 1967
Posey	Plans Pending		1,000 (Estimated needs)	
Putnam	Plans Pending		2,000	
Pulaski	Several School Sites		1,200	In Progress
Ripley	Central Clinic		1,000 (Estimated needs)	
St. Joseph	Several Sites	8,250		Completed
Spencer	Physician's Offices		300	In Progress
Sullivan	Central Clinic		1,400	Nov. 19, 1967
Tippecanoe	Clinic and Hospital	2,200		Completed
Vigo	School Sites and Physician's Offices	2,732		In Progress
Wayne	Physician's Offices and Health Department		380	100 per month thru spring '68
TOTALS		35,948	22,649	

TABLE I

an epidemic is highly effective in aborting the epidemic. No untoward reactions have been reported to the giving of vaccine to children who may have been exposed to measles and are in the stage of incubation.

Where Do We Stand?

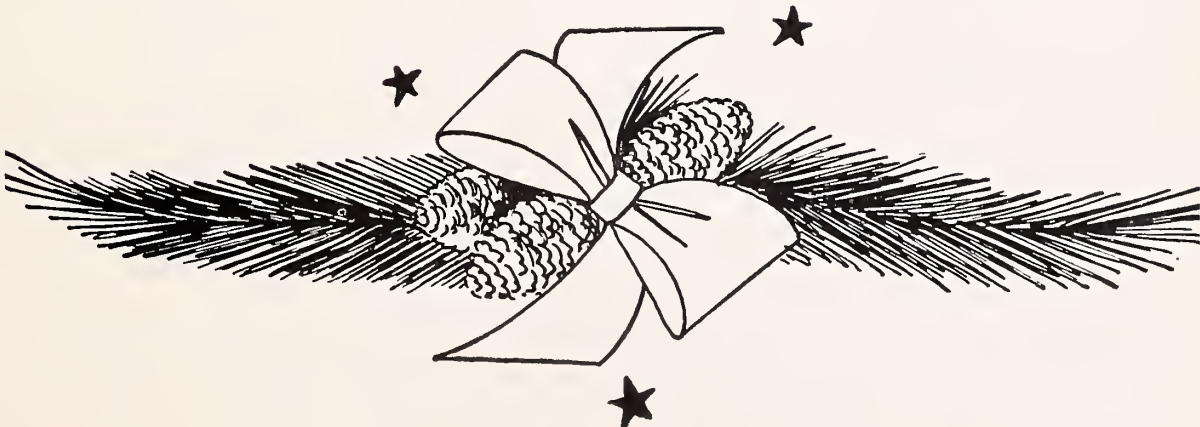
The decision to remove measles from the community rests in the hands of the county medical society and the local health department. Ideally, measles immunization should be accomplished by the private practitioner of medicine as part of an ongoing preventive program of his practice. When a new vaccine is introduced it is necessary for all concerned to immunize as many susceptibles as possible in the shortest period of time to markedly lower the incidence of the disease. This was the case with the eradication of poliomyelitis and will be with each new vaccine. Once the backlog of susceptibles is removed, then the routine immunization of the population by the private practitioner should maintain control.

Table I indicates the counties which have requested vaccine from the Indiana State Board of Health. Table 2 lists counties and quantity of vaccine used in ongoing indigent programs as well as totals of vaccine utilized in 1967 to November 21, 1967. It is recognized that this is not the total measles immunization picture. Some county medical societies conducted programs before vaccine was available from the Indiana State Board of Health. In many commu-

ONGOING INDIGENT PROGRAMS			
County	Doses	County	Doses
Allen	800	Perry	2
Clay	32	Putnam	80
Franklin	110	Ripley	12
Hendricks	2	Rush	75
Henry	73	Scott	208
Howard	103	Sullivan	30
Jackson	46	Vanderburgh	600
Johnson	13	Vermillion	15
Knox	350	Wabash	2
Lake	5760	Warrick	155
Marion	4797		
		TOTAL	13,265
	Doses shipped for ongoing indigent programs		13,265
	Number immunized from reports of completed programs		35,938
	Doses shipped for programs in progress and/or needs for programs approved.		22,649
	Total		71,852

TABLE 2

nities large numbers of children have been immunized in "Operation Headstart." The morbidity reports of 1968 will reveal how successful the efforts of the private physician, county medical societies and local boards of health have been to eradicate measles in 1967.



DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

Physician Not Liable For Staph Infection and Osteomyelitis Following Penicillin Injection—

No evidence of negligence was presented in a suit for damages against a physician by a patient who developed osteomyelitis after a penicillin injection. The patient claimed that the disease was caused by a staph infection introduced into her body on a hypodermic needle used by the physician's nurse in giving her the penicillin injection in the physician's presence. The physician's motion for summary judgment was properly granted by the trial court, a Georgia intermediate appellate court ruled.

The patient alleged that the physician was negligent in not making an allergy test, although he knew she was allergic to penicillin, and in failing to properly sterilize the hypodermic needle that was used. The patient's own evidence established that she suffered no allergic reaction. Evidence that a prepackaged sterilized needle and syringe were used, that this was in accordance with accepted medical practice, and that the nurse's hands never touched the needle was undisputed. Even if it were assumed that there was evidence that the needle was contaminated and was the cause of the patient's ailment, there was no evidence that the physician, his nurse, or anyone in his office knew or, by the exercise of ordinary care, could have discovered, that the prepackaged needle and

syringe were contaminated. Neither was there any evidence that, if the needle and syringe were contaminated, the physician, his nurse, or anyone in his office caused the contamination. Since no question of fact existed as to the issues of negligence or proximate cause, the granting of the physician's motion for summary judgment was proper.

Cohran v. Harper, 154 S.E.2d 461 (Ga., Feb. 7, 1967; rehearing denied, Feb. 21, 1967; cert. denied, April 6, 1967).

Statute on Proof in Malpractice Suits Enacted in Alaska—

A statute relating to the proof required in a suit for damages by a patient against a physician or a dentist for injuries allegedly caused by professional negligence has been enacted in Alaska.

The statute provides that there shall be no presumption of negligence on the part of the physician or dentist against whom the suit is brought. It further provides that the patient has the burden of proving the following: (1) the degree of skill or knowledge possessed or the degree of care ordinarily exercised by physicians or dentists practicing the same specialty in communities similar to that in which the physician or dentist practices; (2) that the physician or dentist lacked this degree of skill or knowledge or failed to exercise this degree of care; (3) that the patient suffered injuries that would not otherwise have occurred

as a proximate result of this lack of skill or knowledge or the failure to exercise this degree of care.

With respect to jury instructions, it provides that the jury shall be instructed that: (1) the patient has the burden of proving, by a preponderance of the evidence, the negligence of the physician or dentist; (2) injury alone does not raise a presumption of negligence on the part of the physician or dentist.

The statute was enacted for the purpose of eliminating the difficulties that were being encountered by physicians and dentists in the state in obtaining professional liability insurance. Some insurers had withdrawn from the field in Alaska, while others had drastically increased rates. The insurers had taken this action on the basis of their interpretation of the decision of the Alaska Supreme Court in *Patrick v. Sedwick*. The insurers interpreted that decision as shifting the burden of proof in malpractice litigation from the patient to the physician or dentist.

Alaska Laws 1967, c. 49 (March 28, 1967).

"New Drug Application" for Enovid Made Available to Patient Suing Manufacturer—

In a suit for damages against the manufacturer of Enovid for heart injuries allegedly caused by use of the drug, a federal trial court granted the patient's motion for an order requiring the manufacturer to produce the correspondence making

up its "New Drug Application." The court ruled that the patient was entitled to inspect and copy the information to aid in her suit against the drug manufacturer.

In her complaint, the patient alleged causes of action for negligence, breach of warranty, strict liability, and misrepresentation. Since the "New Drug Application" was the basis for the manufacturer's license to sell the drug, the patient contended that it was an integral part of the "tort" itself.

The manufacturer argued that the "New Drug Application" could shed no light on the case because it was nothing more than the preliminary negotiations on the licensing of the drug and that those negotiations were necessarily merged into the final labeling that was approved by the government. If that argument were accepted, the court said, a manufacturer would profit by his affirmative deception, reckless representations, or inadequate disclosure, either alone or combined with the Food and Drug Administration's reliance thereon, or its careless or incompetent investigation of the drug.

The patient needed the information over which the manufacturer had control, either as evidence to sustain her suit or to lead her to useful and competent evidence. The government's records which contained a copy of the "New Drug Application" were not available to her. The patient had shown sufficient good cause for ordering the discovery sought, the court said.

Meyer v. G. D. Searle & Co., 41 F.R.D. 290 (D.C., N.Y., Sept. 21, 1966).

Pregnancy After Sterilization Operation is Cause for Suit—

A patient who became pregnant after having undergone a sterilization operation had a cause of action against her physicians, a California intermediate appellate court ruled. The trial court erred in dismissing her suit for damages against three

physicians on the ground that no cause of action was stated.

The patient had nine children. The physicians told her that having more children would aggravate an existing kidney and bladder condition. They recommended that she have an operation for the removal of a portion of the fallopian tubes, which would accomplish a sterilization and improve her physical condition. The patient consented and the operation was performed. She became pregnant ten months later.

The plaintiff alleged that there was insufficient cutting of the tubes and a failure to relocate the tubes anatomically so that they would not regenerate. Those allegations were sufficient to charge the physicians with negligence in the performance of the operation.

The allegations that the physicians failed to tell her that the operation was not foolproof and that there was a possibility she could become pregnant thereafter, with the result that she used no contraceptive device, were sufficient to charge the physicians with postoperative negligence.

The allegations that the physicians failed to inform her of the several surgical procedures by which a complete sterilization could be achieved, thereby depriving her of the opportunity of making an informed choice of which operation she would have, was sufficient to state a cause of action for battery.

The allegations that the physicians told her that she could engage in sexual intercourse with safety and would not have to use contraceptive devices to avoid pregnancy were sufficient to state a cause of action for misrepresentation. Even if the statements were only opinions, as the physicians contended, the patient justifiably relied on them, since the physicians held themselves out as experts and their unequivocal statements implied that they knew facts that justified the statements.

There were also allegations that: there was a written contract that the

physicians would sterilize the patient through an operation and that she would pay a fee for that service; the physicians failed to perform the contract; the patient was damaged by their failure to perform the contract. Although performance by the patient, other than her submitting to the operation, was not clearly alleged, there was sufficient evidence to state a cause of action for breach of contract.

The patient was required to show that some breach of duty on the physicians' part was a proximate cause, but not necessarily the sole cause, of her alleged injuries. The sexual intercourse which resulted in the pregnancy was not an independent intervening cause. Whether their negligence in performing the operation or in failing to tell the patient of its possible temporary nature, or the natural regeneration of the fallopian tubes, was the sole proximate cause, or whether each was a concurring cause, of the pregnancy is a matter of proof.

It was generally recognized that a therapeutic sterilization was not contrary to public policy. It has been suggested that a sterilization for family limitation for personal or socio-economic reasons was also not contrary to public policy. In the absence of a statutory prohibition, the matter would appear to be one of individual conscience, the court said. Since the giving of information, instruction, and medical advice on contraception was now considered a constitutionally protected right, there was some question whether a state could control the matter.

The physicians contended that the pregnancy, the birth of a child, and the expenses of the delivery and the rearing of the child were not legally cognizable injuries. The court disagreed, stating that if a breach of duty by the physicians is established, the patient would be entitled to recover any outlay for the operation, and for any physical complications.

and for mental, physical, and nervous suffering that the operation was designed to prevent.

What other damages would be recoverable could not be determined on this appeal, because the suit was filed before the delivery of the child. Damages that would be recoverable depended on the circumstances of the delivery. If the patient died in childbirth from foreseeable complications of the pregnancy, her husband and surviving children would have a wrongful death action. If she survived but was crippled from the same causes so that she could not perform her maternal and conjugal duties, she could recover for the injuries, and her husband could recover for loss of services and medical expenses. If both the patient and the child survived, she would have to spread her society, care, and support over a larger group. That loss would be recoverable if it could be measured on a monetary basis. Damages would also be recoverable for the expense of rearing the child. The compensation is not for the child, but to provide the family with money so that the child will not deprive the other members of what was planned as their fair share of the family's income. If the patient was successful on the issue of liability, she was clearly entitled to more than nominal damages, the court said.

Custodio v. Bauer, 59 Cal. Rptr. 463 (Cal., May 24, 1967; rehearing denied, June 13, 1967).

Physician's License Revoked for Traffic in Amphetamines—Revocation of a physician's license was warranted after his conviction on nine charges of furnishing dangerous drugs (amphetamines) without a prescription, a California intermediate court ruled. Overruling a trial court order setting aside the Board of Medical Examiners' revocation of the license, the appellate court said that the evidence justified the Board's finding that the convictions were for crimes involving

moral turpitude, which constituted unprofessional conduct. The evidence showed that the physician was merely selling the drugs, rather than prescribing them for patients.

The statute provides that the conviction of an offense, whether felony or misdemeanor, involving moral turpitude constitutes unprofessional conduct. The record of the conviction is proof of only the fact of conviction. The Board may inquire into the circumstances of the commission of the crime to determine whether it was one involving moral turpitude.

Evidence was presented that the amphetamines sold by the physician were habit forming but not addictive. Three women, agents of the state, testified as to their purchases of the drugs from him. They stated that he sold them the drugs on numerous occasions. He never examined any of them, although he did weigh them on some of their visits. He sold drugs to the women for friends of theirs that he had never seen. The total sales of the drugs to the women amounted to supplies for eight months, one year and eight months, and three years and one month. He sold one of the women a six-months' supply on one occasion.

The physician testified that the drugs were no more dangerous than coffee or Coca-Cola. He took the position that selling only a 30-day supply of the drugs was not a violation of the law. He said that the three women were the only persons to whom he had sold a 30-day supply. He presented a statement signed by 485 "patients" that he never sold them more than a one-month's supply at one time. However, no evidence was presented to show that he had examined any of the 485 "patients" before selling them the drugs.

Whether the physician's sale of the drugs involved moral turpitude must be determined on the basis of the standards of policy and morality as related to the proper conduct of the medical profession, a profes-

sion which is required to pay strict attention to laws regulating it, particularly those concerning dangerous drugs. The evidence clearly showed that the physician, in selling the drugs, was not engaging in the practice of his profession and prescribing for patients, but was engaged in the illicit sale of a dangerous drug. The characterization of an act as one involving moral turpitude is a subjective one. The Board had the knowledge and expertise to determine whether the sale of amphetamines to those who asked for them without determining their needs was dangerous. There was ample evidence to support the Board's finding that the physician's sales of the drugs involved moral turpitude, the appellate court ruled.

The trial court had found in effect that the evidence supported the Board in every respect. However, it substituted its subjective idea of what constituted moral turpitude for that of the Board. The appellate court said that there was no merit to any of the grounds on which the trial court based its conclusions that the physician's acts did not involve moral turpitude.

That no disciplinary action had ever been taken against the physician before was irrelevant. On that basis, moral turpitude could never apply to a first offender, no matter what his offense.

It was immaterial that the amphetamines sold had valid medical uses. The physician did not prescribe the drugs for their valid medical uses, but sold them to anyone who asked for them, without determining their need for the drugs.

The fact that the physician testified that he, himself, considered the drugs no more dangerous than Coca-Cola or coffee was unimportant. There was evidence that the drugs, although not addictive, could be habit forming. Further, in a treatise which he wrote, the physician stated that use of the drugs carried the possibility of addiction. The drugs sold

are covered by the statute relating to "dangerous" drugs.

The fact that the physician under-sold the drugstores because his patients were poor people had no bearing on the issue of moral turpitude. The fact that his patients were poor was no justification for the physician's failure to determine whether they needed the drugs.

On the basis of the record, the trial court's judgment was set aside and the revocation order reinstated.

Yakov v. Board of Medical Examiners, 58 Cal. Rptr. 644 (Cal., April 19, 1967; rehearing denied, May 12, 1967).

Internship Not Required for Public Hospital Staff Membership—A physician was entitled to an order enjoining a county hospital

from denying him the use of its facilities and requiring it to admit his patients. The hospital's bylaw requiring an applicant for staff membership to be a graduate of a medical school approved by the American Medical Association and to have had a one-year internship in a hospital accredited by the Joint Commission on the Accreditation of Hospitals was not a reasonable one, an Indiana intermediate appellate court ruled.

The statute relating to the operation of county hospitals provided that physicians having a license to practice medicine without limitations were entitled to use their facilities, except that a hospital's governing board had the right to adopt and enforce reasonable rules and regulations concerning the use of its facilities by

physicians.

The physician had a license to practice medicine without limitations. He was denied staff membership because of his failure to comply with the hospital bylaw requiring graduation from an AMA-approved medical school and internship in a JCAH-accredited hospital.

The bylaw under which the physician was denied staff membership required more rigid training than the statute relating to the issuance of a general license to practice medicine in the state. The hospital's attempt, through the bylaw, to establish more stringent rules for practice within its local jurisdiction exceeded the rule of reasonableness, the court ruled.

McCrary Memorial Hospital v. Hall, 226 N.E.2d 915 (Ind., June 12, 1967). ◀

When Supreme Court Plays Ball

Here's how baseball might be played if the U.S. Supreme Court were the umpire. (Supreme Court, as umpire, in parentheses.)

"And now our national anthem." (We will not have the national anthem since it might increase team pride and the will to win.)

Batter hits home run. (Out! Batter hit ball to right field instead of left.)

Shortstop commits error and throws his glove to the ground. (Shortstop will be fined for mentioning God.)

Batter hits two-bagger. (Runner must return to first base under "one man one base" rule.)

Pitcher throws strike. (Ball! Pitcher had plotted with catcher to deceive batter just before making pitch.)

Perfect double play. (Safe! Double play void because base runners were not notified previously of possible double play attempt.)

Second base steal questioned by opposing team. (Safe! Must always protect the criminal.)

Pitcher picks off runner at first base. (Safe! Pitcher discriminated against other players by throwing to first base.)

Pitcher fakes pick-off play at third base. (Balk! Take home.)

Game called at end of six innings because of rain. Team B wins over Team A 5 to 4. (Team A is declared winner since Team B's manager is religious and probably had prayed for rain so he wouldn't lose the game in later innings.)

Joe Cleveland—From the *Congressional Record*, July 21, 1967.

Physicians' Role in National Blue Shield

(One of a series prepared by Blue Shield)

Physicians play a vital role in the structure and operations of the National Association of Blue Shield Plans.

The board of directors is composed of 33 members — 19 of whom must be physicians. The board has as its responsibility the execution and administration of mandates and policies of the association as determined by its member plans.

The composition of the board reflects the degree to which the medical profession is represented in the overall policy direction of association affairs.

The member plans in each of 11 geographic areas elect two board members. One of these members must be a doctor of medicine in active practice for at least five years and actively serving on the board of

a local plan.

The other district board member may be either an employee of a member plan or a member of its governing board. In either case, the other board member may or may not be a physician.

In addition to the 22 district directors, 11 directors-at-large are chosen. Of these 11, eight are required to be doctors of medicine. Five of the 11 are appointed by the American Medical Association and six are elected by the member plans at the annual business meeting.

In carrying out its responsibilities, the board of directors is assisted by committees appointed to develop and recommend activities to serve the interests of member plans. Physicians play a vital role in these committees, with many physicians serving as

chairmen and members of the various committees.

The executive staff of the National Association of Blue Shield Plans is responsible for implementing the program of activities developed by the committees and approved by the board of directors.

Thus, in effect, physicians guide and direct the affairs of the National Association of Blue Shield Plans and its member plans.

Blue Shield's unique contribution to the medical care field rests upon the voluntary commitment of some 150,000 physicians who have found that Blue Shield helps their patients pay for their services and helps to safeguard the private practice of medicine. ◀

W. C. Huddleston
Public Relations Division





Let's be specific about Campbell's Soups... and reducing diets



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

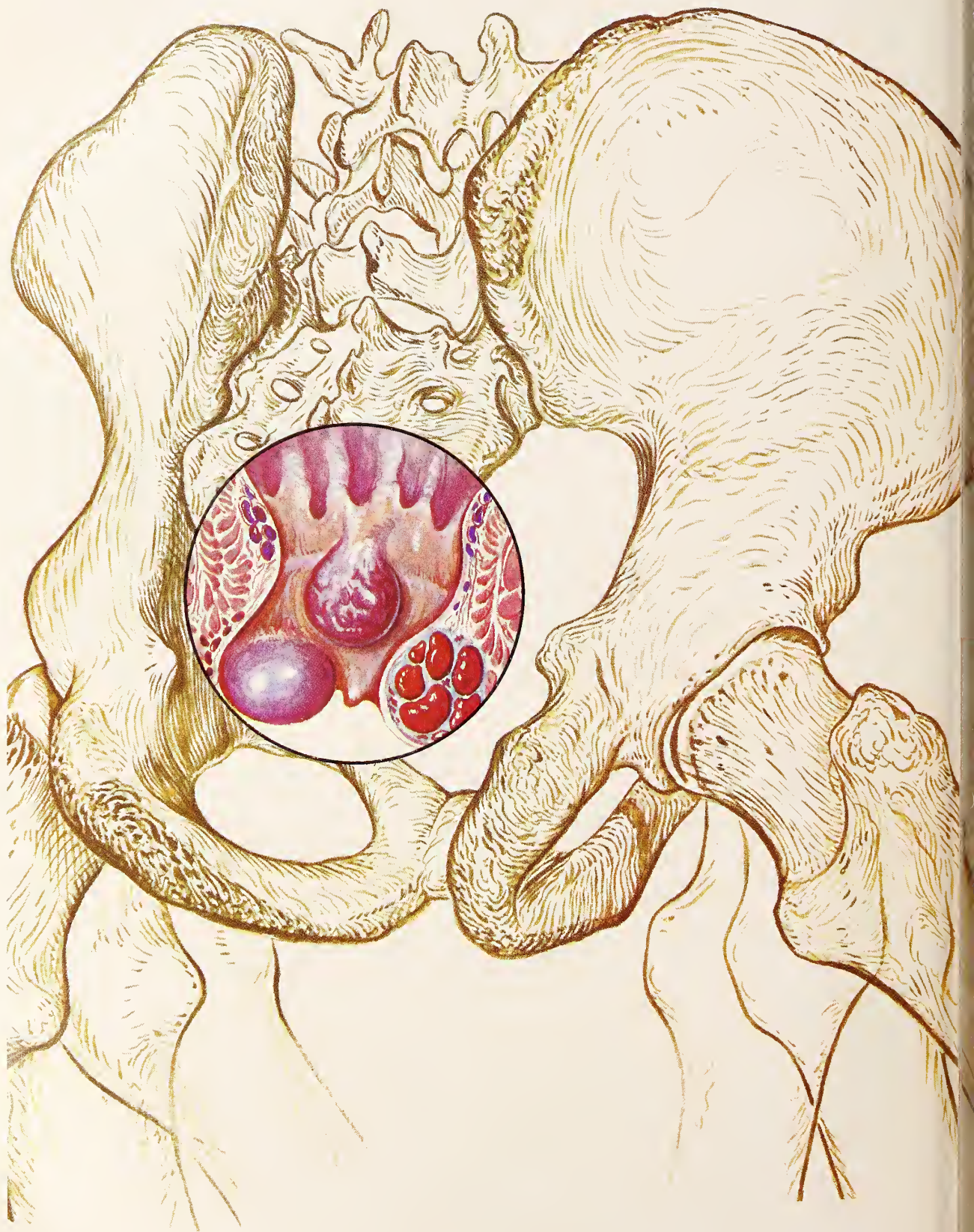
One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.

To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101



For the ambulant patient with hemorrhoids



♦ ♦ ♦ METAMUCIL®

brand of psyllium hydrophilic mucilloid

Relieves strain

Metamucil produces soft, well-formed stools that minimize pain and strain and reduce the chance of thrombosis in hemorrhoidal veins.

Softens stools

Metamucil, a highly purified vegetable colloid, absorbs water, hydrates the intestinal contents and produces a demulcent "smoothage" that aids healing of hemorrhoids and anal fissures.

Reduces pain

Metamucil reduces pain by eliminating the abrasive irritation of hard, dry stools.

Restores bowel function

Metamucil produces a gentle distention of the intestinal wall that stimulates natural peristalsis and helps reestablish normal, rhythmic bowel function.

And in constipation...

Metamucil furnishes, as it has for more than 30 years, the simple physiologic corrective to constipation, eliminating both hard stools and the need for harsh laxatives.

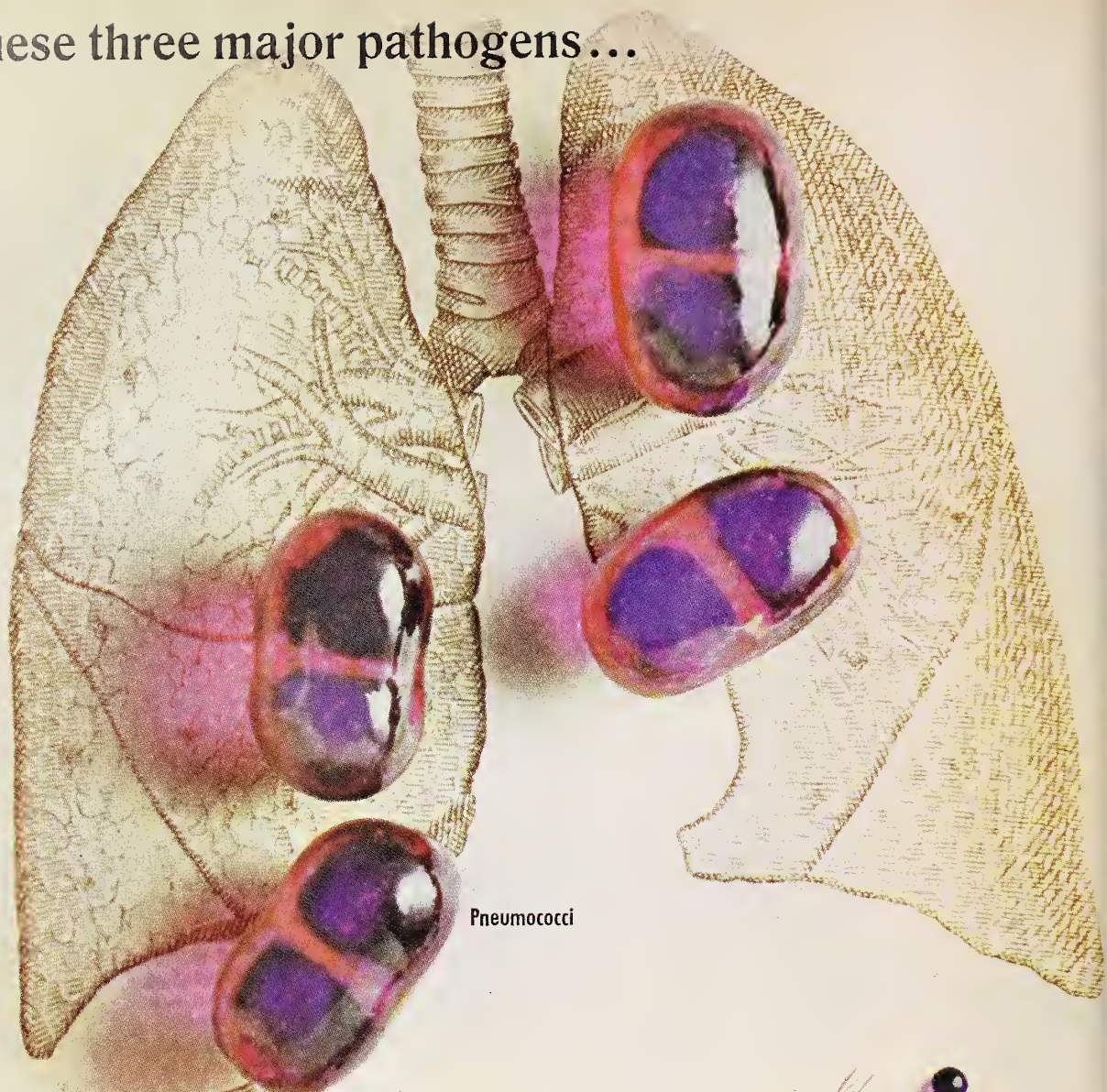
Usual Adult Dosage:

One rounded teaspoonful of Metamucil powder in a glass of cool liquid, or one packet of Instant Mix Metamucil in a glass of water. An additional glass of liquid is helpful.

SEARLE

Research in the Service of Medicine

Against these three major pathogens...



Pneumococci

Penicillin-Sensitive
Staphylococci



Beta-Hemolytic
Streptococci



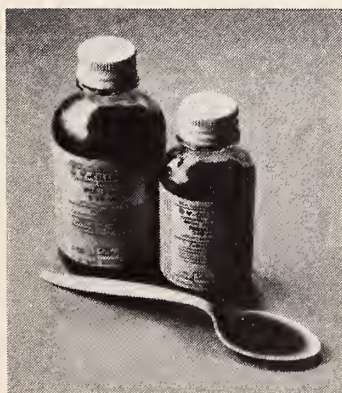
V-Cillin K[®] provides dependable oral antibacterial therapy

because it combines a high degree of activity...

V-Cillin K has been shown to be effective in the treatment of streptococcus and pneumococcus infections as well as infections caused by sensitive strains of staphylococci. It may be used for the prophylaxis of streptococcus infections in patients with a history of rheumatic fever and for the prevention of bacterial endocarditis after tonsillectomy in patients with a history of rheumatic fever or congenital heart disease.

with high blood levels, even when taken with food

V-Cillin K is stable in acid and immediately soluble. High serum levels, therefore, are reached rapidly. Because it is acid stable, V-Cillin K is well absorbed even when taken close to mealtime. These desirable properties help make V-Cillin K a dependable penicillin for oral use.

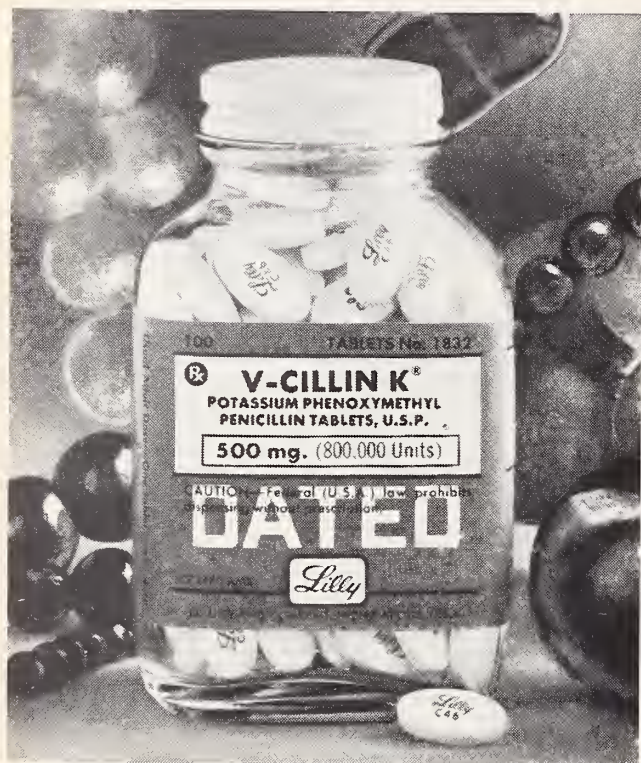


V-Cillin K[®] 701449 Potassium Phenoxymethyl Penicillin

Now available: V-Cillin K[®], Pediatric,
for Oral Solution, 250 mg. (400,000 units)
per 5 cc. of solution.

(See next page for prescribing information.)

New 500 mg. tablets...a more convenient way to give high doses



Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K, U.S.P., 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K, Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567]

Additional information available to physicians upon request. Eli Lilly and Company, Indianapolis, Indiana 46206.



The Cancer You View

DISCUSSION

Mammography was requested by the clinician. The 2.5 cm. mass appeared opaque and poorly margined due to spiculation secondary to its invasive character. There was associated skin thickening and skin retraction (including, in this case, the nipple), diagnostic of cancer. Other secondary signs of cancer in the mammogram include enlarged axillary lymph nodes, prominence of the venous structures, and fine calcification in the mass. The mass is usually described as larger on clinical examination than at mammography.

Evidence of malignancy often is demonstrable radiographically before it is recognized clinically. The breast cancer discovered by mammographic screening studies is smaller, has fewer secondary manifestations, and is more often free of axillary metastases than cancers discovered by the clinician. Carcinomas as small as 4 mm. have been demonstrated in a clinically negative postmenopausal breast.

Mammography has become an accepted and generally used radiologic procedure in the investigation of breast diseases. The renewed interest and utilization have arisen because of technical advances in the radiologic field and the lack of improvement in the overall survival statistics in cancer of the breast in this century.

After approximately 40 years of unfulfilled hope in radiologic investigation of breast diseases, Egan¹, in 1960, published a new and reproducible technic for the performance of mammography. This procedure in-

volves only soft tissue radiographic technic, requiring no injections of air or contrast media; as a result, it has found general patient acceptance. It is safe, reliable, reproducible, and depends less on the skill of the roentgenologist in interpretation than on the meticulous care with which mammograms are made.

The team approach to the diagnostic problem of breast diseases is emphasized by all concerned, and by no one more than the mammographer. Though mammography is highly accurate, it has its shortcomings. The radiologist realizes the paramount importance of cooperation among clinician, surgeon, roentgenologist and pathologist in arriving at a treatment plan for each patient.

The accuracy of the procedure varies only in minor degree in the hands of various mammographers. Of benign lesions, approximately five percent will be overdiagnosed as cancers. Of malignant lesions, about 80% will be correctly diagnosed. The 20% that are underdiagnosed, unfortunately, are the same lesions that give the surgeon and clinician the greatest diagnostic difficulty. However, the surgeon's accuracy of clinical diagnosis is about 70%, and as a result, a number of cancers will be picked up by the mammographer which have been missed by the previously routine approach. The important point is that by a combined team approach, a diagnostic accuracy of 90% is achieved prior to biopsy.

Coincidence of carcinomas in both breasts is approximately three to four percent. The chance of a second cancer developing in the remaining

breast following radical mastectomy is in the neighborhood of 10%. This points up the value of mammography prior to the initial mastectomy for assessment of the opposite breast, as well as for serial follow-up of the remaining breast, perhaps at yearly intervals.

Mammography is of greatest value in the postmenopausal patient, where the adipose replacement of normal tissue renders cancers of small size most demonstrable. It decreases in value in the patient under 45 years of age, as the breasts increase in density due to the presence of normal glandular structures. Fortunately carcinoma decreases in frequency with decreasing age, and is less common in those patients below 45 in whom radiologic study of the breast is of least value.

A resume of the indications for mammography would include the following:

1. As a screening procedure for women past the menopause, regardless of symptoms. The yield of such an approach is somewhat debated and still under investigation, but it will probably prove to be of equal or greater value than such procedures as routine cervical screening with the Papanicolaou technic.

2. In the woman with nodular breasts due to fibrocystic disease to elucidate the nature of the individual masses and recognize the cancer which may be obscured clinically by other palpable nodules.

3. To aid the clinician in the assessment of the doubtful palpable mass.

4. For examination of the contralateral breast at the time a mammary cancer is diagnosed by the clinician.

5. For serial follow-up of the remaining breast following mastectomy for cancer.

REFERENCE

1. Egan, R. L.: Experience with mammography in a tumor institution—Evaluation of 1,000 studies, *Radiol.* 75:894-900, 1960. ◀



The relief received from the first Trocinate 400 mg. tablet is so prompt that the discomfort of diarrhea ceases to be a bother. May be repeated every four hours.

Upon request, a supply of Trocinate 400 mg. with literature will be sent to physicians for their personal use.

WM. P. POYTHRESS & CO., INC.

RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

Diarrhea

TROCINATE® 400 MG.

BRAND THIPHENAMIL HCl.

ABSTRACTS

BOOK REVIEWS

SURGERY OF THE PAROTID GLAND

Robin Anderson, M.D., Louis Byars, M.D., the C. V. Mosby Company, St. Louis, 1965; 177 pages; \$12.75.

This book is one of the few texts devoted to disorders of the parotid gland and is based on the authors' experience over a 25-year-period. The chapters on pathology and anatomy are well written and are accompanied by excellent illustrations. The text is basically devoted to the various clinical entities that confront the surgeon interested in problems of disorders and tumors related to the parotid gland. Most of the book deals with the management of these problems, both from the medical and surgical approaches. The philosophy that these men have concerning the medical problems and surgery of this area is thorough and leaves nothing uncovered. Every aspect of disorders of the salivary gland and tumors involving this area is well covered.

The only criticism that I could make concerning this book would be in the surgical approach. I think that in the hands of Dr. Byars, the technic of wide surgical excision is acceptable, but for most young men learning surgery of the parotid compartment, I am of the opinion that a nerve tumor type dissection is preferable. I think that the authors could have emphasized more definitely the value of exposure of the facial nerve in its main undivided position as it emerges from the stylo-mastoid foramen and the importance of following the cardinal surgical principle of dealing with the problem at hand after isolation of the important anatomy in the area. The part of the book devoted to diagnosis brings up the controversy over biopsy of tumors of the parotid. The authors did not take a firm stand in relation to this problem, but review the dangers and limitations of aspiration and formal incisional biopsy.

I think this book should be a part of every surgeon's library who is interested in diseases and tumors of the parotid gland.

R. E. LINGEMAN, M.D.
Indianapolis

THE EFFECTS OF EXTERNAL STIMULI ON REPRODUCTION

Edited by G. E. W. Wolstenholme and Maeve O'Connor, Ciba Foundation Study Group No. 26, Little, Brown and Co., Boston, 1967; 104 pages, index, and 10 illustrations; "In Honour of Professor B. Zondek." (Prof. Zondek took part in the proceedings, but died while this book was in press.)

Since this book is a verbatim report of a one-day study—a meeting of research scientists comparing notes, so to speak—there is some question as to its value for practitioners of medicine, at this time. However, the participants are all seasoned experts and the discussions of each paper, wherein great frankness prevails, are a good tonic for anyone who feels that "researchers" are sometimes prone to flights of fancy.

All of the reports are of work done on experimental animals, so that the application of results to man has yet to be made; but the physician who likes to play with new ideas and who has a lively curiosity will be intrigued by the possibilities envisioned in this booklet.

There is growing concern as to the effect of noise on people who are unable to escape it in their daily tasks. Many effects have been noted, but here is a study of noise in relation to reproduction. In rats, the adult females showed changes in oestrus

rhythm—prolongation or persistence. The weight of the ovaries increased 62.7%, with many corpora lutea. In immature animals there was no such effect. Also, in male rats spermatogenesis continues normally. In rabbits, increase in ovaries up to three times normal weight occurred, and in some, lactation was produced. On the other hand, auditory "stimulation of females and males in the pre-mating period leads to a considerable decrease in the capacity of the males to fertilize and of the females to be fertilized." Stimulation in the four-day mating period reduces the number of pregnancies and also the number of fetuses. Stimulation of rats for 48 hours after mating induces interruption of pregnancy. In rats made deaf by Kanamycin, these effects do not occur (Dr. Zondek).

Dr. A. Arvay, of Hungary, used sound, light, and electric stimuli on rats and found evidence of increased gonadotropic activity. He also found changes in fertility of animals and altered viability of the fetus, plus an increase in incidence of malformations.

H. M. Bruce, of Cambridge, England, reported definite effects from olfactory stimuli not only in the adult female mouse, but also in the young during suckling.

D. H. Thorpe, Birmingham, England, found that environmental lighting is a major factor governing the time of oestrus in the ferret.

When asked about the intensity of noise necessary to affect rats compared with that to which human beings are constantly subjected now, Dr. Zondek said that jet planes would certainly affect rats and even much lower noises are sufficient. He also stated that even in deaf rats, supersonic sounds disturbed the maintenance of pregnancy.

Although some differences of opinion regarding pathways in the nervous system were aired in the discussions, it seemed clear that the gonadotropic effect of external stimuli was mediated via the hypothalamus. While the participants in this symposium were frank to admit that they are just getting a good start in this field, their work thus far is at least provocative and already provides much food for thought. Indeed, I am even now reminded of one old-fashioned remedy for infertility which often worked, and that was to advise the couple to take a two or three weeks vacation at the seashore. While the ocean may roar, it is not like the noises of civilization.

A. W. CAVINS, M.D.
Terre Haute

Abstracts From Various
Literature, Prepared by AMA

GANGRENOUS EXTREMITIES RESULTING
FROM INTRA-ARTERIAL INJECTIONS

H. S. Engler et al. (Department of Surgery, Medical College of Georgia, Augusta)
Arch. Surg. 94:644-651, (May), 1967.

Eight patients are presented in whom medications intended for intravenous injection were inadvertently injected into the artery. There is immediate blanching of the extremity, with intense vasoconstriction of the small arteries and arterioles. Swelling of the extremity occurs within 24 hours, as does muscle necrosis. The large arteries usually remain patent, the major injury being to small arteries, arterioles, and capillaries.

EXPLORATORY GASTROTOMY IN THE
MANAGEMENT OF MASSIVE
GASTROINTESTINAL HEMORRHAGE

R. J. Freeark, W. J. Norcross, and R. J. Baker (1825 W. Harrison St., Chicago)
Arch. Surg. 94:684-695, (May), 1967.

If at the time of laparotomy the source of bleeding is not apparent, exploratory gastrotomy appears preferable to empiric resection. Seventy-seven patients with acute massive bleeding required gastrotomy for intraoperative diagnosis and treatment. In 47 patients with no abnormality noted prior to gastrotomy, the following diagnoses were established: gastric ulcer (15), Mallory Weiss syndrome (11), duodenal ulcer (8), hemorrhagic gastritis (5), ruptured sclerotic vessel (3), and miscellaneous causes (2). In a second group of 30 patients, an obvious abnormality was noted on opening the abdomen, but uncertainty regarding its relationship to the bleeding necessitated gastrotomy. Included are patients with cirrhosis of the liver (12), splenomegaly (3), masses in and around the stomach (7), and patients with subserosal discoloration typical of the Mallory Weiss syndrome (5). Gastrotomy established the relationship between the bleeding and the specific abnormality in each instance. Bleeding site was accurately identified in 74 of the 77 patients.

LINCOMYCIN IN THE TREATMENT
OF OSTEOMYELITIS

N. L. McMillan, R. K. McRae, and A. McDougall (St. Joseph's Hospital, Elliott Lake, Ontario, Canada)
Practitioner 198:390-395, (March), 1967.
Lincomycin given in prolonged dosage of 500 mg six-hourly

ARTIFICIAL LIMB
WEARERS

Hanger Limbs are being successfully worn by amputees of all ages. David Canfield, just 13 months (illustrated), is one

Age: 13 Months

of the many young children growing up on Hanger Legs. In contrast, Captain W. T. Traylor, over 75 (illustrated), now wears his fifth Hanger. He is a fire inspector who must cover continually hospitals, schools, sports events, etc., and be on his feet for hours at a time.

The success of Hanger Limbs with amputees of such widely varying types can be largely attributed to custom manufacture and individual fitting. Unusual conditions are carefully investigated by experienced fitters, and limbs are manufactured to meet individual requirements.

Age: 78 Years

Hanger's experience of over 100 years is given to every amputee so that his rehabilitation may be successful.



Hanger
PROSTHETICS

AIR CONDITIONED OFFICES
1332 N. Illinois St., Indianapolis, Ind. 46202
3108 Burnet Avenue, Cincinnati, Ohio 45229
446 W. Pontiac Street, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711

has been evaluated in the treatment of 25 patients with osteomyelitis. The response in all patients was excellent and, with the exception of two patients who were given courses of inadequate duration, there have been no recurrences during a follow-up period of not less than two years.

PARTIAL THICKNESS SKIN GRAFTING OF FINGERTIP INJURIES

R. Salaman (53 Madingley Rd., Cambridge, England)

Lancet 1:705-707, (April 1), 1967

A follow-up of 51 patients who had sustained fingertip injuries which had been treated by means of immediate partial-thickness skin grafting showed that satisfactory results had been obtained.

SEAT BELT TRAUMA TO THE ABDOMEN

J. Sube, H. H. Ziperman, and W. J. McIver (Department of Surgery, William Beaumont General Hospital, El Paso, Texas)

Amer. J. Surg. 113:346-350, (March), 1967.

Two cases of abdominal injuries due to lap-type seat belts are presented and the literature reviewed. In the first patient laparotomy revealed 1,500 cc of free intraperitoneal blood and a contused but intact segment of distal ileum with a five-inch rent in the mesentery. Bilateral retroperitoneal hematomas were present in the vicinity of both the cecum and sigmoid. At laparotomy the second patient was found to have two complete transections of the jejunum two and five inches distal to the ligament of Treitz. Intra-abdominal injuries from this type of seat belt are infrequent and in no way contraindicate the use of this often life-saving device.

CHLORPROMAZINE: ADJUNCT TO PHYSIOLOGICAL PERFUSION

M. Lemieux et al. (Department of Surgery, New York University School of Medicine, New York)

J. Thor. Cardio. Surg. 53:425-429, (March), 1967.

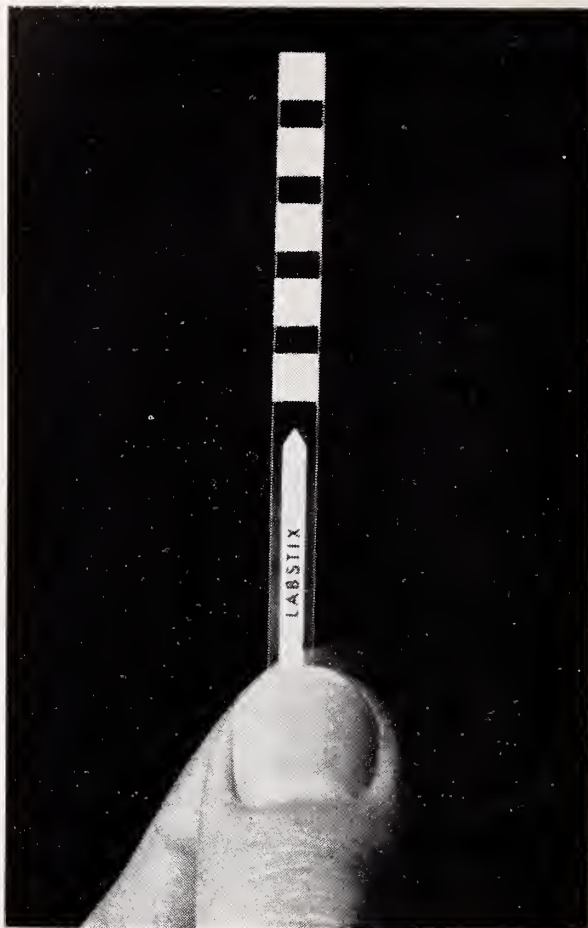
Thirty adult patients with acquired heart disease who had operative correction or replacement of defective valves received chlorpromazine intravenously. Cardiopulmonary bypass at flow rates of 2 to 2.4 liter/min/sq m was effected with roller pumps. The increases in percent oxygen saturation of venous blood and in urine output in response to chlorpromazine indicated improved perfusion and organ function, at times to a dramatic degree. No operative deaths or late complications could be attributed to the use of chlorpromazine. Chlorpromazine exerts beneficial effects upon blood flow by decreasing peripheral resistance. Abnormal tonus is combated directly through its adrenolytic properties. Active vasodilation occurs, mediated through ganglionic blockade.

OBSTETRICAL PROBLEMS COINCIDENTAL TO INTRAUTERINE TRANSFUSION FOR ERYTHROBLASTOSIS

R. F. Friesen (409 Medical Arts Building, Winnipeg, Manitoba)

Canad. Med. Assoc. J. 96:1079-1083, (April 15), 1967.

In a series of 49 cases given 100 intrauterine transfusions for erythroblastosis, numerous obstetrical problems were encountered which were not directly related to the procedure. All of the mothers endured considerable emotional strain. Complications,



Take five...

LABSTIX® provides 5 important urinary findings*—on a single reagent strip! That's *more* information than you can get from any other single reagent strip. You know the results in just 30 seconds—while the patient is still in your office—and readings are reliable and reproducible. LABSTIX is easy to handle, too. Never goes limp, even when wet, because it's made with clear, firm plastic. And results with LABSTIX are easy to read—color contrast between the test areas and the transparent plastic is clearly defined. An unexpected "positive" from testing with LABSTIX may help in detecting hidden pathology before marked symptoms are manifest.

*Blood; ketones; glucose; protein, and pH.

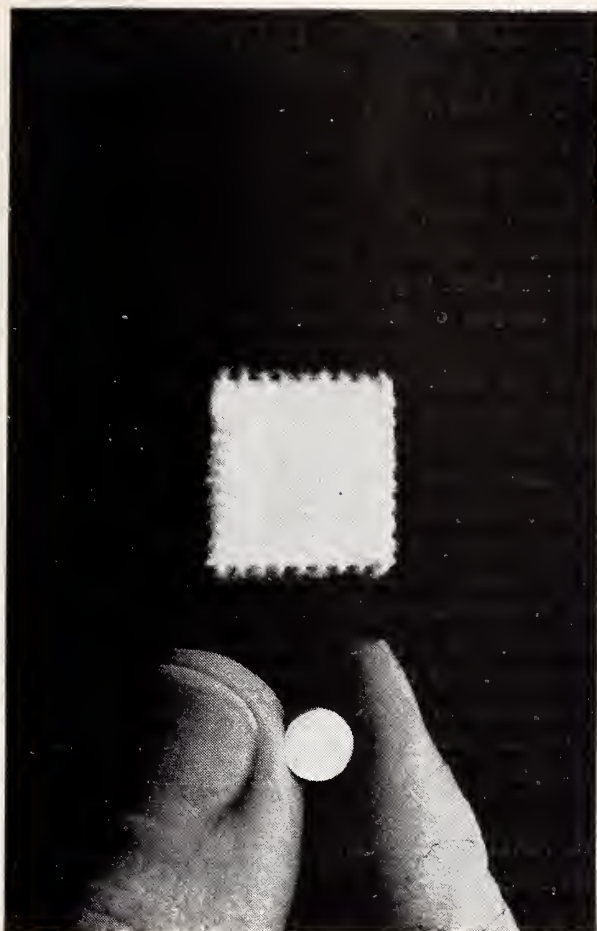
AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514



Ames

Note: AMERICAN HOSPITAL FORMULARY SERVICE
CATEGORY NUMBER 36:88

40167



...Plus one

You can extend your testing scope by including ICTOTEST® Reagent Tablets, the 30-second determination for bilirubinuria—which can be an early sign of obstruction of the common bile duct, infectious hepatitis, or other liver disease. This test is also useful for detecting liver damage from carbon tetrachloride and other halogenated hydrocarbons used as industrial and household solvents. Positive findings with the urine-testing team of LABSTIX and ICTOTEST can represent significant guides to patient management in many clinical situations. "Negatives" may help rule out suspected abnormalities over a broad clinical range and are important for the patient's record.

AMES COMPANY
Division Miles Laboratories, Inc.
Elkhart, Indiana 46514



Ames

Note: AMERICAN HOSPITAL FORMULARY SERVICE
CATEGORY NUMBER 36:88

40167

which in previous pregnancies contributed to producing their Rh sensitization, tended to recur. Deliveries were carried out between 26 and 35 weeks' gestation, at which stage induction was difficult and labor imperfect. In 24 cases the fetus was alive at the onset of labor. The other 25 cases presented the problems of intrauterine death, nine of which occurred in the dangerous second trimester. Because of these coincidental obstetrical problems and the difficulties inherent in intrauterine fetal transfusion, these cases should be managed in centers prepared to deal with all possible complications and having the necessary equipment.

HOSPITAL-ACQUIRED SALMONELLOSIS TRACED TO CARMINE DYE CAPSULES

L. E. Komarmy, M. E. Oxley, and G. Brecher (University of California Medical Center, San Francisco)

New. Eng. J. Med. 276:850-851, (April 13), 1967.

Five patients hospitalized for chronic gastrointestinal complaints had *Salmonella cubana* isolated in stool cultures during a four-week period. Two additional patients with *S. cubana* in their stool were found after reviewing laboratory records. All of these patients had ingested capsules of carmine dye as a stool marker during diagnostic studies, before the stool cultures were obtained. Cultures of dye taken from capsules and pharmacy stock bottles of carmine dye contained *S. cubana*.

CARMINE AS SOURCE OF NOSOCOMIAL SALMONELLOSIS

D. J. Lang et al. (Massachusetts General Hospital, Boston)

New. Eng. J. Med. 276:829-831, (April 13), 1967.

Twenty-one cases of *Salmonella cubana* infection occurred, among which 16 were apparently acquired in hospital. Simultaneously, additional apparently unrelated infections with this rarely reported bacterium were recognized. Most of the hospital-acquired cases were associated with the ingestion of contaminated carmine dye. Carmine, which is used primarily to color foods, drugs, and cosmetics, is derived from an insect; historical and epidemiological factors indicate that a close relationship between the insect and bacterium may have existed for years. Investigations stimulated by this outbreak have revealed the presence of *S. cubana* in several foods colored with carmine. Human infection with *S. cubana* may be infrequently recognized because of inadequate laboratory procedures. Caution is urged in the prescription and use of items administered to hospitalized patients and others at risk.

NEW NONOPERATIVE TECHNIQUE FOR DIAGNOSIS OF PENETRATING INJURIES TO THE ABDOMEN

W. P. Cornell et al. (926 E. McDowell Rd., Phoenix, Arizona)

J. Trauma 7:311-314, (March), 1967.

A two-year experience of injection of 112 penetrating abdominal wounds with radiopaque material is presented. The method has been reliable and easy to perform. Initially, the first 20 patients with no evidence of contrast material in the peritoneal cavity were explored to confirm the validity of the study. Fifty-four patients with negative injection studies have been observed



I'll admit that's quite a cough you've got there!

SCIENTIFIC SHOE FITTING

Since shoes are the foundation for the entire body they deserve scientific fitting as to the person's size, last and foot shape.

If abnormalities exist we apply arches, metatarsal bars, wedges, Thomas heels and the necessary shoemaking alteration to encourage helpful function of the foot and limbs. Only then can the shoe enable proper stance, posture and walking satisfaction for man, woman, child.

This service is assured by experienced shoe fitters and trained Orthopedic shoemakers. Both must work together to get the best results. A pharmacist compounds a prescription so should a professional shoe fitter make applications for shoe corrections.

Heid's follow up service during the life of the shoe is also of utmost importance since the response may differ with each individual. Often a slight alteration makes for lasting comfort and satisfaction.

This scientific shoe fitting and corrective application is a service offered by Heidenreich and Son who operate the Heid's Health Shoe Store at 411 N. Illinois St., Indianapolis, Indiana.

Your referrals and prescriptions will receive accurate, conscientious attention at reasonable, ethical charges. No job too big, none too small.

for 24 hours and none of these patients has developed signs of intra-abdominal injury or required operation.

STERILE, CONVENIENT, ECONOMICAL DISPOSABLE SPINAL ANESTHESIA TRAYS—FACT OR FANTASY?

L. D. Bridenbaugh (1118 Ninth Ave., Seattle), D. C. Moore, and J. C. DeVries

Anesth. Analg. 46:191-194, (March-April), 1967.

Approximately 967 spinal blocks were administered using disposable spinal block trays which contained the anesthetic drugs. Computer analysis of these blocks comparing onset, duration, and complications with 11,419 spinal blocks revealed no statistically significant difference and no neurological complications. A retrospective study of the neurological complications reported from the use of 757,848 disposable spinal block trays showed no complications from the use of 242,018 trays containing no drugs. Thirty-four patients had documented "aseptic meningitis," two patients had septic meningitis, and five patients had symptoms of meningitis but the spinal fluid was not examined. All recovered without neurological residual and the complications were apparently due to pyrogens in the dextrose. Different drugs have been substituted on 156,830 trays, with no reported neurological complications. The economy of the disposable trays depended on the availability of hospital personnel to prepare hospital trays.

RENAL ARTERY ANOMALIES AND HYPERTENSION

P. W. Robertson et al. (Royal Air Force Hospital, Cosford, England)

Amer. Heart. J. 73:296-307, (March), 1967.

Renal angiograms were obtained on 340 patients with hypertension. Two hundred twenty-five patients were assessed as having idiopathic or essential hypertension and of these, 152 (67%) were shown to have a renal arterial anomaly. Such arterial anomalies may be associated with renal dysplasia. Association between renal artery anomaly and idiopathic hypertension may be significant.

MYOCARDIAL INFARCTION IN YOUNG MEN

W. J. Walker (White Memorial Medical Center, Los Angeles) and G. Gregoratos

Amer. J. Cardiol. 19:339-343, (March), 1967.

One hundred military men who survived a transmural myocardial infarction at age 40 or below were compared with age-matched military controls. The most striking correlation found in the infarct group was the elevated serum cholesterol, elevated total serum lipids, obesity, and a family history of coronary artery disease. Other factors associated to a statistically significant degree with myocardial infarction were hypertension, short stature, cigarette smoking, consumption of saturated fats, low intake of unsaturated fats, emotional tension, white race, and family history of hypertension. No association was found with coffee consumption, alcohol consumption, degree of physical activity, history of peptic ulcer, hematocrit, frequency and extent of baldness, or family history of diabetes mellitus or gout. ◀



let and other information on the fund is available through the Indiana University Foundation, Memorial Union Building, Indianapolis, Indiana.

Riley Memorial Association Announces New Series of Visiting Professorships

Establishment of a series of visiting professorships in pediatrics and the creation of a visiting lectureship in plastic surgery at the James Whitcomb Riley Hospital for Children have been approved by the Board of Governors of the Riley Memorial Association.

Designated as the William C. and Ruth P. Griffith Visiting Professorships in Pediatrics, the approved program will bring to the hospital each year four eminent pediatricians for lectures and consultation. Dr. Morris Green, chairman of the department of pediatrics, hailed the establishment of the series, voted by the board to recognize the long service of Mr. Griffith as a member of the Board of Governors of the Riley Association, as a means of "direct contributions to service and to education which such educators and scholars would assuredly make in their visits." Dr. Green pointed out further that "they could also help us greatly as they are impressed by what they see, by encouraging their young students and research fellows to come here [to Riley] for house staff and junior faculty appointments. This potential dividend of such a program could be substantial and possibly achieved in no other fashion."

Mr. Griffith was elected a life governor of the association January 25, 1967 after serving 21 years as an active member of the Board of Governors.

A group of 20 former students of Dr. Harold M. Trusler, who recently retired as chairman of the plastic surgery section of Riley Hospital, requested the Riley Association to administer a fund raised by the physicians who trained as residents under Dr. Trusler to support a Visiting Lectureship In Clinical Plastic Surgery in his honor. The board voted to cooperate in the administration of the fund. Dr. Trusler was the first intern trained at Riley Hospital and though retired continues on the staff.

In other action the board voted approval of project billings for research and educational activities at Riley Hospital in the sum of \$32,012 and \$10,429 for patient care which brings to a total of \$2,209,497 in private gift funds expended from association sources in these areas.

Five new bequests were reported to the association for the quarter. Payments of approximately \$300,000 were made to the association from bequests and \$35,000 from other fund sources. New gifts to the hospital, mainly from individuals, totaled \$3,782 and to Camp Riley for Physically Handicapped Children at Bradford Woods, near Martinsville, \$2,554.

The camp provided outdoor fun, recreation, handicraft training and other such benefits in three sessions last summer to 174 children for a total of 3,541 camper days.

Drs. Miller and Arata Honored

Drs. Mahlon F. Miller and Justin E. Arata, Fort Wayne, were elected officers of the Indiana Chapter of the American College of Surgeons at a recent meeting at the University of Notre Dame. Dr. Miller was made president-elect and Dr. Arata was re-elected secretary-treasurer.

"Manual on Alcoholism" Booklet Now Available to Physicians

"Manual on Alcoholism," a new publication of the AMA, is an 87-page book which covers concisely the diagnosis and treatment

1967 Campaign of the Indiana University School of Medicine Fund

The 1967 campaign of the Indiana University School of Medicine Fund is in progress, and alumni and friends are being given another opportunity to make contributions to help meet needs of the school. The fund program is now in its fourth year under the sponsorship of the school, the Medical Alumni Association, and the Indiana University Foundation.



Dr. J. O. Ritchey of Indianapolis is serving as national chairman for the second year and 220 local chairmen are working in communities throughout the country. Ninety-six of these local chairmen are within the state of Indiana. Dr. Earl W. Mericle is serving for the second year as chairman for Indianapolis. He has organized "a committee of 100" to contact more than 800 graduates of the I.U. School of Medicine living in Indianapolis.

Officers of the various classes of the school are writing to their classmates, and it is anticipated that again gifts will be received from every class. More than \$250,000 has been raised in this fund program during its first three years. Last year gifts were received from 1,800 donors representing 480 communities throughout the nation.

These statistics relate only to gifts from alumni and friends resulting directly from the campaign conducted for this fund by the Indiana University Foundation. The figures do not include donations which many graduates assign to their alma mater through the American Medical Education Foundation of the American Medical Association. The school of medicine, of course, is equally grateful for all gifts received from all sources.

The Medical Alumni Association has prepared a booklet showing the uses made from annual giving contributions to meet important needs for which no other funds are available. This book-

Synirin provides prompt barbiturate potentiation of aspirin without limiting the therapeutic usage of aspirin. Both pentobarbital and aspirin begin their action together promptly and last 4 or 5 hours. There is no accumulation.

LITERATURE AND CLINICAL SUPPLY AVAILABLE TO PHYSICIANS

**SYNIRIN is another
pharmaceutical achievement**

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856



Synirin®

ACETYL SALICYLIC ACID (ASPIRIN)..... 5 GR.
*PENTOBARBITAL (ACID)..... 1/8 GR.
*Warning: may be habit-forming

of alcoholism. Thirteen authorities submitted resource information for the manual.

The material was edited by Robert J. Shearer, M.D., former associate director of the AMA Department of Mental Health. To obtain write Order Handling Unit, AMA, 535 N. Dearborn, Chicago 60610. Prices are 50 cents a copy (40 cents for medical students, interns and residents).

New CIBA Representative

Mr. David W. Gasaway has been appointed as the new CIBA representative in the Indianapolis territory.

Reprints of "Examination of the Mouth" Available to Physicians

Reprints of an article which describes a simple but effective procedure for examining the mouth are now available to interested physicians and dentists. Called "Examination of the Mouth," the pamphlet is illustrated with 24 figures, 14 of them in color, and contains nine case reports. Authors are Drs. William L. Ross, Robert H. Johnson, and Richard L. Hayes, who stress the value of such examinations in detecting a variety of diseases, including malignancies.

Single copies of the article, which originally appeared in the August 1967 issue of *GP*, are free upon request. Requests for copies in excess of 10 should be accompanied by an explanation of how the copies will be distributed or used. Write Information Services, Cancer Control Program, Public Health Service, 4040 North Fairfax Drive, Arlington, Virginia 22203.

Dr. Garrison Gives Talk

Dr. James L. Garrison, Cumberland, recently discussed the film "Sex—The Moral Dilemma of Teenagers" with the youth of St. John United Church of Christ, Cumberland.

Ayerst Laboratories Offers Movie Films to Physicians

A new medical movie film "Bacterial Meningitis" is now available from Ayerst Laboratories. The film is in color and sound and running time is 25 minutes. It discusses the differential diagnosis and technics of treatment of bacterial meningitis.

Ayerst also has films on "Chronic Bronchitis—A Team Affair" (color, sound, 30 minutes) and "Reprieve from Lethal Infection" (color, sound, 18 minutes). Medical groups interested in viewing the films may write Dr. Michael J. Maffei, 685 Third Ave., New York City 10017.

Physicians Elected

Dr. Harold D. Caylor, Bluffton, retiring president of the Indiana chapter, American College of Surgeons, was elected one of the organization's councilors at a recent meeting in South Bend.

Dr. Alexander W. Cavins, Terre Haute, was also named a councilor.

\$25,000 for Heart Research Granted By Marion County Heart Association

Grants-in-aid for research amounting to \$25,000 have been approved by the research committee of the Marion County Heart Association, according to an announcement by Dr. Harvey Feigenbaum, chairman.

The grants bring to \$56,295 the total funds which have been provided by the association for local heart research in the last four years. State and national research programs are also supported by the local organization each year.

The 1967 grant recipients and the titles of their projects are:

Angenieta A. Biegel, M.D., instructor in medicine at Indiana University Medical Center, \$6,500. "The Typing of Human Lymphocytes In-vitro, and Its Use in Renal Transplantation."

Donald A. Girod, M.D., assistant professor of pediatrics, Indiana University Medical Center, \$3,500. "Determination of Minimal Electrocardiographic Data Effective for Discrimination of Neonates with Congenital Cardiac Defects from Normals."

Roy H. Behnke, M.D., professor of medicine at I.U. School of Medicine, and chief of medicine, Veterans Administration Hospital, Indianapolis, \$2,665. "The Effect of Morphine on the Peripheral Resistance and Capacitance Vessels of Patients with Heart Failure."

Kahuan Greenspan, Ph.D., head of the physiology section, Krannert Institute of Cardiology, \$7,100. "Effect of Ions and Drugs on Cardiac Electrophysiology and Bioenergetics."

Richard C. Powell, M.D., assistant professor in medicine, Indiana University, \$5,235. "The Influence of Dietary Fats on Control of Carbohydrate-Induced Lipogenesis in Humans."

The grants-in-aid to Drs. Biegel, Girod and Greenspan are renewals for projects already under way, while those to Drs. Behnke and Powell are for new research.

Dr. Guild Discusses Development Center

Dr. John K. Guild, Plymouth, discussed activities at the Marshall-Starke Development Center during a recent county Junior Leader meeting. Dr. Guild is a member of the board of directors of the development center.

Dr. Penrod is Speaker

Dr. Kenneth E. Penrod, provost of the Indiana University Medical Center, recently spoke on "Changes are Coming in the Health Care Industry" to members of the Indianapolis Alumni Chapter of Phi Kappa Phi.

Life Insurance Company Offers Standard Rate Insurance to Epileptics

The Institutional Life Insurance Company of Indianapolis, after review of life expectancy of epileptics and study of the actuarial statistics, is selling standard life insurance policies to non-institutionalized epileptics at standard rates.

Higher premiums have been the policy of the industry for many years. It is thought that Institutional is the first company to insure epileptics at standard rates. Physicians may obtain copies of their brochure on the subject by writing the company at 2951 E. 38th St., Indianapolis 46218.

Dr. Buchanan to be Honored

Dr. Wallace Buchanan, South Bend, will receive a gold medal from the American College of Radiology, at its annual meeting in February in Chicago, in recognition for his outstanding work in support of separate billing for radiologists, as well as for his leadership in the College.

He is a former chairman of the College's Board of Chancellors and is now chairman of its Committee on Private Practice and Independent Billing. The College will also present Gold Medals to Dr. Juan A. del Fegato, Colorado Springs, for his major contributions in radiation therapy, and Dr. Russell H. Morgan, Baltimore, for leadership in the field of radiation protection.

Cardiopulmonary Resuscitation Film Available to Hospitals, Medical Schools

Cardiopulmonary resuscitation is covered in all its aspects in

removes the mental blur



that clouds vision

SOLFOTON[®]

Each tablet or capsule contains
PHENOBARBITAL.....16 mg.
(Warning: may be habit forming)
BENSULFOID[®] (See P D R).....65 mg.
Precaution: same as 16 mg. of phenobarbital



Constructive Therapy

A Solfoton tablet or capsule at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Literature and clinical samples sent upon request.

FEDERAL LAW PROHIBITS DISPENSING
WITHOUT PRESCRIPTION

AVAILABLE

Solfoton (yellow, uncoated tablets "P")
100s, 500s, 5000s
Solfoton Capsules (yellow and brown)
100s, 500s, 1000s
Solfoton S/C (sugar-coated beige tablets)
100s, 500s, 4000s

WM. P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

a new 50-minute, 16mm, full color medical training film.

The film was produced under the direction of Dr. Archer Gordon, a member of the American Heart Association Cardiopulmonary Resuscitation Committee, and has the approval of the U. S. Public Health Service. Its use is limited to hospitals and medical schools. For details write Bandelier Films, Albuquerque, New Mexico.

Dr. Huth Named

Dr. Edward J. Huth, Bryn Mawr, Pennsylvania, associate editor of the *Annals of Internal Medicine* was installed as president of the American Medical Writers' Association at its recent annual meeting in Chicago. Dr. Harold Laufman, Director of the Institute for Surgical Studies, New York City was chosen as president-elect.

Dr. Silver Elected

Dr. Richard A. Silver, Indianapolis is the new president of the Indiana Roentgen Society. **Dr. John A. Robb, Indianapolis** is president-elect; **Dr. Edwin F. Koch, Jr., Muncie**, is secretary and **Dr. Samuel Morchan, Indianapolis**, is treasurer.

Dr. Robert E. Beck, Evansville and **Dr. James G. Lorman, Fort Wayne** have been elected councilors of the American College of Radiology. **Dr. William J. Stangle, Bloomington**, and **Dr. Wallace S. Tirman, South Bend**, are alternate councilors.

American College of Surgeons Inducts Indiana Surgeons into Fellowship

The American College of Surgeons, at its recent five-day annual Clinical Congress in Chicago, inducted 1,445 surgeons into Fellowship. This is the largest group of new Fellows in the

history of the College. Twenty-one of the class were from Indiana as follows:

Clarence R. Woodbury, Anderson; Farrell Mock, Bluffton; Victoriano G. Viray, Jr., Crawfordsville; Mitchell E. Goldenberg, East Chicago; William F. Briney, Lewis W. Knight, William B. Rank, Fort Wayne; Walter E. McDonald, George J. Volan, Gary; James C. Lett, Greencastle; Donald J. Vandertoll, Highland; Robert E. Bakemeier, Indianapolis; Eldon L. Gerig, Mishawaka; John V. Osborne, Muncie; Wilbur J. Marshall, Jr., Munster; Paul Waitt, Noblesville; Franklin M. Booth, George M. Haley, South Bend; James E. Keplinger, West Lafayette; William C. Brennan, Young S. Kim, Whiting.

Dr. Quinnell Named

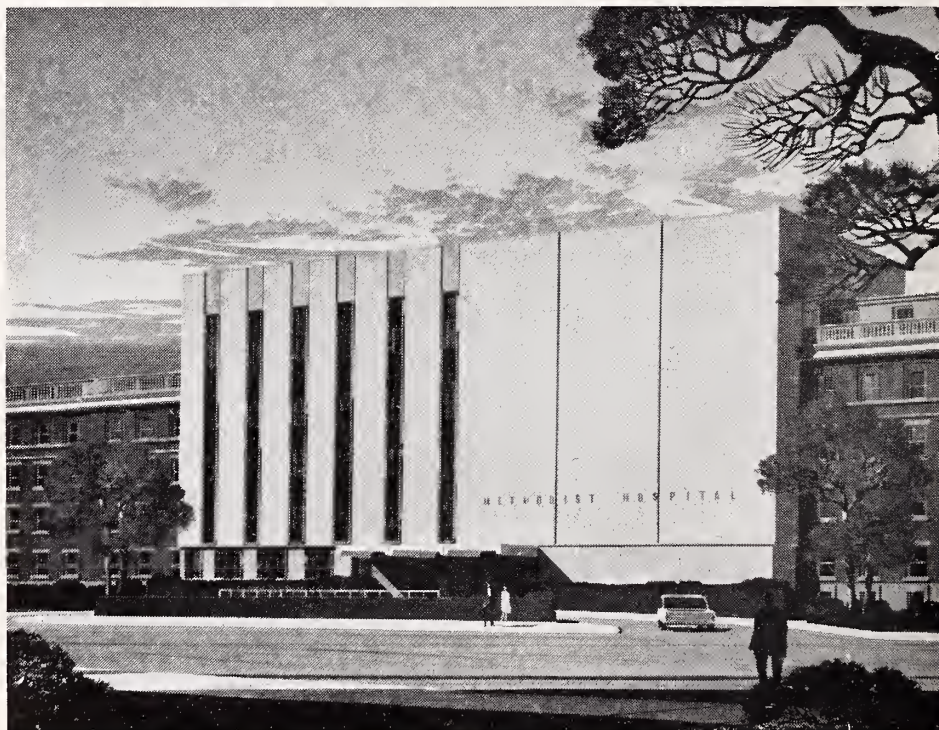
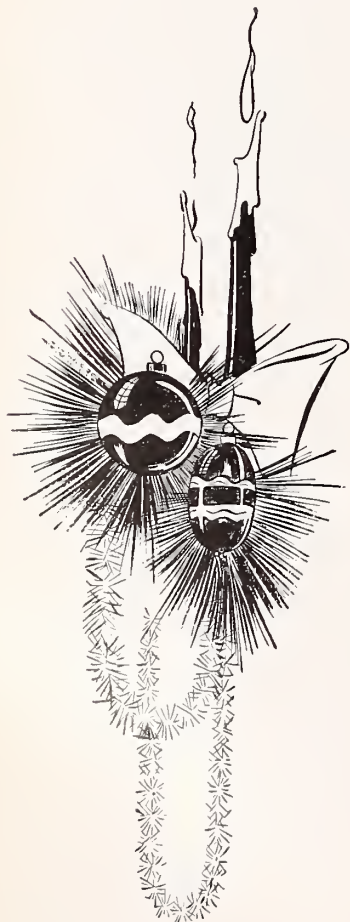
Robert K. Quinnell, M.D., has been appointed director of the Office of Medical Relations of the Pharmaceutical Manufacturers Association. Dr. Quinnell has recently retired from the medical service of the U. S. Air Force and has been occupied recently with the aerospace medicine program.

Dr. Egger is Speaker

Dr. Ross L. Egger, Middletown, presented a talk on "Cancer" at a recent meeting of the Chesterfield Kiwanis Club.

Dr. Sandock Wins Award

Dr. Louis F. Sandock, South Bend, was recently awarded the 1967 Brotherhood Award of the South Bend-Mishawaka Chapter of the National Conference of Christians and Jews. ◀



CONSTRUCTION of a \$6.5 million two-wing addition to Methodist Hospital, Indianapolis, is underway. Scheduled for completion in late 1969, the new structure will add 128,250 square feet of floor space. This addition is part of the hospital's current building program, totaling more than \$19 million. Greatly needed expansion of laboratory, x-ray and operating room areas will be possible in a six-story professional services wing. A companion wing across the front of the hospital will change the basic appearance of the hospital's main building for the first time in 50 years. It will provide additional administrative offices, expanded pharmacy, outpatient and physical therapy facilities. Other new features will be a cardiovascular diagnostic laboratory for determining appropriate treatment or management of heart diseases and a research nursing unit for developing special patient care technics.

WANTED: Physicians Locations

GENERAL PRACTICE

D. Kent Hobert, 929 Willow, Martinez, Calif. 94553

Adriano C. Trinidad, Jr., 3994 President Dr., Cincinnati, Ohio 45225—with surgery

Kent D. Ferguson, Sharpe Army Depot, Lathrop, Calif. 95330—available 8/68

Robert J. Ailes, 99922 Kealaluina Dr., Aiea, Oahu, Hawaii 96701—available 8/68

SPECIALISTS

Moises Safirstein-Roszman, Michael Reese Hospital, Chicago, Ill. 60616—Anesthesiology

Harry W. Scott, 2788 De Foors Ferry Rd., N.W., Apt. 2A, Atlanta, Ga. 30318—Dermatology

Richard Y. Kimura, Barnes Hospital, Dermatology Div., St. Louis, Mo. 63110—Dermatology

Hector Mario Echegaray, University of Utah Medical Center, Salt Lake City, Utah 84112—Cardiology

Henry F. Rohs, 1916 Schweir Court, Indianapolis, Ind. 46220—Internal Medicine

Harvey M. Rosenbaum, 3740 Washington Blvd., Cleveland, Ohio 44118—Internal Medicine

Tom M. Johnson, 2107 Alice Dr., Ann Arbor, Mich. 48103—Internal Medicine

Agustin D. Palattao, Jr., 207 N. Lockwood St., Chicago, Ill. 60644—Internal Medicine

Jesus F. Pangan, P. O. Box 326, Crown Point, Ind. 46307—Internal Medicine

Dale R. Wassmuth, 1125 Tower Court, Iowa City, Iowa 52240—Internal Medicine

Richard E. Linback, 814 E. St. Clair St., Indianapolis, Ind. 46202—Internal Medicine—Cardiology

Victor J. Magary, 2086-A Werner Park, Fort Campbell, Ky. 42223—OB-GYN

Philip L. Kuebbeler, 64 Myron Ave., Indianapolis, Ind. 46241—OB-GYN

Eugene S. Martinowsky, 7400 W. 183rd St., Tinley Park, Ill. 60477—Psychiatry

David J. Katz, Qts. 4-31, USMA, West Point, N.Y. 10996—General Surgery

David Hare Harshaw, Jr., 4508 Cherokee Ave., Lawton, Okla. 73501—General Surgery

Richard D. Colquitt, 10 Spring St., Las Vegas, Nev. 89110—General Surgery

Juanito V. Fernandez, 4001 Tampa Bay Blvd., Tampa, Fla. 33614—General Surgery

George H. Dy, Rm. 351, Wellington Bldg., Binondo, Manila, Philippines—Surgery

Ambalal K. Patel, V. A. Hospital, Oteen, N. C. 28805—General Surgery

Jose Caram Flores, 1533 10th St., S. E., Rochester, Minn. 55901—Surgery

Shun C. Young, Roswell Park Mem. Inst., Buffalo, N. Y. 14203—General Surgery

Donald V. Jablonski, 19912 Woodside, Harper Woods, Mich. 48236—Urology

Gerland L. Engelsgerd, 1324 Gilmore St., Mountain View, Calif. 94040—Urology

Moses M. A. Saiphoo, 30 Queensway, Toronto 3, Ontario, Canada—Urology

Phillip R. Reiff, 419 S. 78th St., Omaha, Nebr. 68114—Administrative position with medical background

ADDITIONAL LOCATIONS

SPECIALISTS

County Town

Allen—FORT WAYNE—population 164,000 located in the northeastern part of Indiana. Three hospitals. Need for physicians specializing in allergy, anesthesiology, dermatology, ear, nose and throat, internal medicine, neurology, neurosurgery, obstetrics and gynecology, ophthalmology, orthopedics, pathology, pediatrics, psychiatry, radiology, cardiovascular surgery. For details contact Larry Pickering, Executive Secretary, Fort Wayne Medical Society, 212 Medical Center Building, Fort Wayne 46802.

Lake—MUNSTER—population 11,000 located in the northwestern part of Indiana close to Chicago. The Hammond Clinic, 7905 Calumet Ave., has openings for general practitioners, urology, orthopedics, otolaryngology and internal medicine. Contact Mr. Donald W. Moore, Director.

ADDITIONAL LOCATIONS GENERAL PRACTITIONERS

County Town

Allen—FORT WAYNE—population 164,000 located in the northeastern part of Indiana. Three hospitals. Need for several general practitioners. For details contact Larry Pickering, Executive Secretary, Fort Wayne Medical Society, 212 Medical Center Building, Fort Wayne 46802.

Daviess—WASHINGTON—population 11,000. County hospital—137 beds. Fully equipped office with complete x-ray and orthopedic equipment of a recently deceased physician available. Contact Mrs. C. Philip Fox, 505 N. E. 12th Street, Washington 47501.

Lake—MUNSTER—population 11,000. Located in the northwestern part of Indiana close to Chicago. Need for general practitioners at the Hammond Clinic, 7905 Calumet Ave., Munster 46321. Contact Mr. Donald Moore, Director of the Clinic.

Newton—KENTLAND—Need for a general practitioner to replace a physician who has retired. This town serves as the central shopping area for a large wealthy agricultural community. Close to Chicago. Office and equipment available. Financial aid available. Possible association with only other physician in town. Contact Mr. T. A. Kenney, 103 E. Graham, Kentland—Phone 219-474-5188 or Mr. George James, Consultant, George Ade Hospital, Brook, Indiana, Phone 219-275-2531.

Franklin—BROOKVILLE—population 2,600—located in the east-central part of Indiana. Located 17 miles from Connersville and 40 miles from Cincinnati, Ohio where hospital facilities are located. Principal economies are agriculture and industry. Contact Mr. Carl W. Fassold, 700 Main St., Brookville 47012.

Randolph—LYNN—population 1,500 with a population of 6,000 within a ten mile radius. Hospitals located at Winchester, 13 miles, and Richmond which is 15 miles away. One semi-retired physician in the town. Lions Club interested in finding one or two general practitioners for the community. Contact Mr. Leroy Horner, R. R. 2, Lynn, Indiana 47355.



Your Contributions Are Needed . . .

SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans \$12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.



**American Medical Association
Education and Research Foundation**

**535 North Dearborn Street
Chicago 10, Illinois**

Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL
ASSOCIATION ANNUAL
CONVENTION**

Date June 16-20, 1968

Place San Francisco, Calif.

**AMERICAN COLLEGE OF SURGEONS,
INDIANA CHAPTER**

Date May 17-18, 1968

Place Stouffer Inn, Indianapolis

**INDIANA STATE MEDICAL
ASSOCIATION CONVENTION**

Date October 14-17, 1968

Place Fort Wayne

**NORTHERN INDIANA
PSYCHIATRIC SOCIETY**

Date Fourth Wednesday of every month,
September through June

Place For location and program, inquire
Beatty Memorial Hospital,
Westville

**INDIANA ACADEMY OF
GENERAL PRACTICE**

Date March 26-28, 1968

Place Indianapolis

**INDIANA PUBLIC HEALTH
ASSOCIATION**

Date April 30-May 1, 1968

Place Howard Johnson's Motor Lodge,
Indianapolis

**INDIANA NEUROPSYCHIATRIC
ASSOCIATION**

Date Second Wednesday of the month,
October through May, excluding
December

Place The Athenaeum, Indianapolis

**INDIANA ACADEMY OF OPHTHAL-
MOLOGY AND OTOLARYNGOLOGY**

Date May 1-2, 1968

Place Culver Inn, Culver

**INDIANA SOCIETY OF
ANESTHESIOLOGISTS**

Date May 25-26, 1968

Place Marott Hotel, Indianapolis

INDIANA ROENTGEN SOCIETY

Date May 5, 1968

Place Indianapolis

**INDIANA OBSTETRICAL AND
GYNECOLOGICAL SOCIETY**

Date January 10, 1968

Place Stouffer Inn, Indianapolis

**INDIANA STATE DENTAL
ASSOCIATION**

Date May 19-20, 1968

Place Murat Theater, Indianapolis



when he just can't sleep
Tuinal[®]

**One-Half Sodium Amobarbital and
One-Half Sodium Secobarbital
supplied in $\frac{3}{4}$, $1\frac{1}{2}$, and 3-grain Pulvules[®]**



Tuinal helps wakeful patients fall asleep fast, stay asleep all night.

Indications: Tuinal is indicated for prompt and moderately long-acting hypnosis. It is not suitable for continuous daytime sedation.

Contraindications: Barbiturates should not be administered to anyone with a history of porphyria, nor should they be given in the presence of uncontrolled pain, because excitement may result.

Warning: May be habit-forming.

Precautions: Tuinal should be used cautiously in patients with decreased liver function, since prolongation of effect may occur.

Adverse Reactions: Idiosyncrasy, such as excitement, hangover, or pain, may appear. Hypersensitivity reac-

tions occur in some patients, especially in those with asthma, urticaria, or angioneurotic edema.

Overdosage: C.N.S. depression. **Symptoms**—Depression of respiration and of superficial and deep reflexes, slight constriction of the pupils (in severe poisoning, dilation), decreased urine formation, lowered body temperature, coma. **Treatment**—Symptomatic and supportive (gastric lavage; intravenous fluids; maintenance of blood pressure, body temperature, and adequate respiration). Dialysis may speed removal of barbiturates from body fluids.



Dosage: 50-200 mg. ($\frac{3}{4}$ -3 grains) at bedtime.

[031767]

Additional information available to physicians upon request.
Eli Lilly and Company • Indianapolis, Indiana 46206



INDIANA STATE BOARD OF HEALTH

MONTHLY REPORT—October, 1967

Disease	Oct. 1967	Sept. 1967	Aug. 1967	Oct. 1966	Oct. 1965
Animal Bites	760	1134	1091	753	711
Chickenpox	91	26	24	92	85
Conjunctivitis	42	43	47	65	89
Diphtheria	1	0	0	0	0
Dysentery, Unspecified	33	32	22	62	46
Gonorrhea	398	583	428	421	347
Impetigo	204	139	96	188	224
Infectious Hepatitis	63	33	32	35	35
Infectious Mononucleosis	53	41	8	72	43
Influenza	777	226	32	509	739
Measles					
Rubeola	24	5	7	47	171
Rubella	21	9	25	24	41
Meningitis, Meningococcal	1	4	0	3	4
Meningitis, Other	3	6	3	3	7
Mumps	65	82	142	109	60
Pertussis (Whooping Cough)	24	50	36	6	4
Pneumonia	153	99	92	146	329
Poliomyelitis	0	0	0	0	0
Streptococcal Infection	446	301	250	348	462
Syphilis					
Primary & Secondary	29	15	16	6	6
All Other Syphilis	51	101	66	52	65
Tinea Capitis	2	11	0	13	5
Tuberculosis (Active)	65	85	63	98	96

"COCA-COLA" AND "COKE" ARE REGISTERED TRADE-MARKS WHICH IDENTIFY ONLY THE PRODUCT OF THE COCA-COLA COMPANY.



FUTURE MEETINGS, SEMINARS, COURSES

First International Conference On Prematurity Will be January 11-13

The First International Conference on Prematurity, sponsored by the AMA Committee on Maternal and Child Care, will be held January 11-13, 1968 at Pier 66, Ft. Lauderdale, Florida.

The program has been planned around three morning sessions to explore the problems of prematurity in depth with particular emphasis on obstetrical prevention and pediatric intervention with the ultimate objective of reducing perinatal losses. International speakers will discuss patterns of prematurity, mortality and morbidity factors, pathogenic implications, and national and international newborn programs.

Those interested in receiving additional information about registration for this conference are requested to write Wesley J. Duiker, Secretary, Committee on Maternal and Child Care, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

"General Practice Review" Course Offered on January 14-20

The University of Colorado School of Medicine announces a seven-day postgraduate course, The Fourteenth Annual General Practice Review, to be held January 14 through 20, 1968, in Denver. This course features one day devoted to each of six major fields of practice: medicine, pediatrics, dermatology, surgery, obstetrics and gynecology, and trauma. Physicians who do not wish to attend the entire course may register for selected days. The registration fee is \$10.00 and the tuition fee for the entire course is \$75.00 or \$15.00 per day.

Invitations and detailed programs for the General Practice Review postgraduate course may be obtained by writing to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colorado 80220.

"Mental Retardation — Modern Approaches" Course Offered January 10

The third annual "Frontiers of Medicine" series will present a course on "Mental Retardation—Modern Approaches" January 10 at the University of Chicago Hospitals and Clinics.

Further details on the programs and information on registration may be obtained by writing David M. G. Huntington, Administrative Coordinator, Committee on Continuing Medical Education, the University of Chicago, 950 E. 59th St., Chicago 60637.

Postgraduate Courses Listed by Cleveland Clinic Foundation

A course on "Treatment of Surgical Emergencies" will be conducted at the Cleveland Clinic Educational Foundation on January 17 and 18, 1968. "General Practice" is the title of another postgraduate course offered on January 31 and February 1, 1968.

Further information and programs may be obtained by writing the Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

"Postgraduate Symposium in Nuclear Medicine" Set for St. Louis in January

There will be a "Postgraduate Symposium in Nuclear Medicine" with the faculty to be comprised of the staff of the Mallinckrodt Institute of Radiology, Washington University Medical School and fifteen visiting lecturers to be conducted in the Institute in St. Louis, Missouri, on January 17, 18 and 19, 1968.

The symposium will have two parts: (1) Introduction to Nuclear Medicine on January 17, and (2) Progress in Nuclear Medicine on January 18 and 19. Address Dr. E. James Potchen, Director, Nuclear Medicine, 510 S. Kingshighway, St. Louis 63110 for further information.

Postgraduate Course on "Surgery Of the Hand" to be in Colorado

The University of Colorado School of Medicine announces a four-day postgraduate course on "Surgery of the Hand," to be held February 20 through 23, 1968, in Denver. The course will cover specific subjects in the field of trauma of the hand with consideration given to immediate and delayed management of these injuries.

Four eminent guest speakers will participate: Robert E. Carroll, M.D., New York, New York; Raymond M. Curtis, M.D., Baltimore, Maryland; William L. White, M.D., Pittsburgh, Pennsylvania; and James N. Wilson, M.D., Los Angeles, California. Registration and tuition fees are \$80.00.

For further information and a detailed program, write to: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colorado 80220.

"World Problems in Rehabilitation Of the Disabled" Set for England

The Third International Seminar and Exhibition on the theme "World Problems in Rehabilitation of the Disabled" will be held at the Hotel Metropole, Brighton, England from June 30 to July 6, 1968 under the sponsorship of the British Council for Rehabilitation of the Disabled.

For full details and forms write: The General Secretary, REHAB, Tavistock House (South), Tavistock Square, London, W.C.1, England.

Two-Day Workshop Scheduled by Institute of Medicine of Chicago

The Institute of Medicine of Chicago will conduct a two-day workshop on "The Doctor and His Hospital", at the Pick-Congress Hotel in Chicago on March 7 and 8, 1968. Problems which have arisen as a result of the hospital orientation and hospital concentration of medical practice will be studied.

Panels have been selected on Medical Staff Responsibility for Utilization of Hospital Services, The Hospital as a Teaching and Research Institution, Logistics in the Hospital, Hospital Costs, Nursing in the Hospital, The Hospital and the Community, Alliance of Medicine and Religion in Hospitals, and The Impact of Federal Funding on Hospital Practice. Write the Institute at 332 S. Michigan Ave., Chicago 60604. ◀



Optimil®

THE OPTIMUM-NUTRITION INFANT FORMULA

OPTIMUM CONTENTMENT

New Optimil's marked superiority in achieving satiety — reflected by infants' infrequent crying — is most reassuring to mothers.

Excessive appetite and inordinate crying in the infant are symptoms of essential fatty-acid deficiency. There may be insufficient linoleic acid in the diet, or the conversion of linoleic to metabolically-active arachidonic acid may be blocked by an inhibitory fatty acid. Optimil maintains optimum tissue levels of arachidonic acid by providing linoleic acid at 9% of total calories, with only a trace of linolenic acid, the potent blocking agent.¹⁻⁵

OPTIMUM DIGESTIBILITY

New Optimil provides protein, fat and carbohydrate in kinds and amounts more consistent with the infant's needs. Spitting-up is minimized and skin integrity maximized.

Human milk is still the ideal food for human infants, and Optimil is closer in balance of major nutrients than any competitive infant feeding. Optimil contains a high level of unsaturated fat (58%), a low level of stearic acid (2%), the least digestible fatty acid, and an ample level of oleic acid (40%) to enhance absorption of unsaturated fatty acids.⁶ (Fat retention of Optimil is over 90%.) Processing of Optimil protein produces minimum curd tension.

OPTIMUM GROWTH

New Optimil's superior nutritional balance of major nutrients and their components provides highest caloric efficiency. Optimum protein and mineral content assures lowest renal solute load.

Because Optimil is so similar to human milk and maintains high tissue levels of arachidonic acid, it offers superior caloric efficiency for optimum growth. The protein and mineral content is lower than that of any competitive infant formula. Therefore the osmolarity of Optimil is also the lowest. This extended formula has demonstrated its ability to provide optimum growth in comparative studies with leading modified-milk infant formulas.⁷⁻⁹

Optimil is available for your specification at leading drugstores in the new, full 16-fluid-ounce can. Dilutes 1 to 1 with water to provide a full quart of formula, a full day's supply.

1. Hepner, R., et al.: Pediatrics 33:94, 1964. 2. Hepner, R., et al.: Pediatrics (to be published). 3. Hansen, A. E., et al.: Pediatrics 31:171, 1963. 4. Holman, R. T.: Fed. Proceed. 23:1062, 1964. 5. Holman, R. T., et al.: Amer. J. Clin. Nut. 14:83, 1964. 6. Young, R. J., and Garrett, R. L.: J. Nut. 81:321, 1963. 7. Hepner, R.: "New Perspectives on Nutritional Aspects of Modified Milk-Fat Formulas," a colloquium held under the auspices of The Pediatric Department, Western Reserve University School of Medicine, Cleveland, Ohio, Sept. 8, 1966. 8. Carson, M., and Hart, L.: *ibid.* 9. Nichols, M.: *ibid.*



Optimil, the first optimum-nutrition infant formula

from a world leader in nutritional research... **Carnation**

County, District News

Tenth District

The Tenth District Medical Society met October 4 to hear talks by Dr. D. W. Lindner, chairman of the Detroit Medical Society Disaster Committee and Lt. Anthony Bertoni, of the Detroit Police Department. They presented an illustrated description of their experiences during the civil disorders in Detroit in July. New officers elected were: Drs. John J. Reed, Hobart, president and Raymond Doherty, Crown Point, secretary.

Adams

Prosecuting attorney Richard Sullivan spoke on the "Legal Aspects of Blood Alcohols" at the October 17 meeting of the Adams County Medical Society.

Bartholomew-Brown

New officers of the Bartholomew-Brown County Medical Society are: Drs. Forest J. Daugherty, president; Brockton L. Weisenberger, vice-president and C. David Ryan, secretary-treasurer. All of the new officers are from Columbus.

Boone

Dr. James R. McAfee, Lebanon, is the newly elected president of the Boone County Medical Society; Dr. Thornton Perkins, Lebanon, is the newly-elected vice-president and Dr. Katherine A. Jackson, Zionsville, the new secretary-treasurer.

Dearborn-Ohio

The Dearborn-Ohio County Medical Society met October 5 to hear Dr. Gary Scudder speak and show slides on South Vietnam.

Elkhart

A panel discussion on cancer highlighted the October 5 meeting of the Elkhart County Medical Society meeting.

Fort Wayne

Dr. Calvert Stein spoke on "Clinical Hypnotherapy" at the October 3 meeting of the Fort Wayne (Allen County) Medical Society.

Hancock

Dr. R. E. Lingeman, Indianapolis, spoke on "Throat Masses" at the October 23 meeting of the Hancock County Medical Society.

LaPorte

The LaPorte County Medical Society met October 16 to hear Dr. Milton Weinberg, chief of the Chest Disease Service at Cook County Hospital, speak on "Surgical Management of Cardiopulmonary Problems."

Parke-Vermillion

Dr. Ludimere Lenyo, internist at the P & S Clinic, Terre Haute, and Mr. Allan Erickson, program director for the Indiana division of the American Cancer Society, spoke at the October 18 meeting of the Parke-Vermillion County Medical Society. Their topic was "Detection of Breast Cancer and Pediatric Cancers."

Putnam

"Psychiatric Problems in General Practice" was the topic of Dr. William Davis, Ladoga, when he spoke at the October 15 meeting of the Putnam County Medical Society.

Vanderburgh

Dr. John Campbell, professor and chairman of radiology at Indiana University School of Medicine, spoke on "New Trends in Radiology" at the October 3 meeting of the Vanderburgh County Medical Society. ◀



1967 - The Convention Story



THE COUNCIL met at breakfast Monday morning to labor over business matters.



THE HOUSE OF DELEGATES met Monday afternoon in the Ballroom of the Columbia Club.

MRS. JOHN W. DEEVER, president of the Woman's Auxiliary, addresses the House of Delegates.



REFERENCE COMMITTEE NO. 2 met Monday evening to deal with a multitude of resolutions.



REGISTRATION Tuesday morning.



JOURNAL POLICY PLANNERS: The Editorial Board.



DR. GOETHE LINK, Indianapolis, addressed the Section on Surgery at a noon luncheon Tuesday.



THE PAST PRESIDENTS OF ISMA met for luncheon on Tuesday at the Columbia Club.



DR. EDWIN E. PONTIUS, Indianapolis, discusses his scientific exhibit with Dr. Frank H. Coble, Richmond.



PHYSICIANS jam the aisles in the sections for technical exhibitors.

THE first general meeting of the convention featured talks by Dr. Stuart Allen Kleit, Indianapolis and Dr. Henry G. Hadley, Washington, D.C.



MRS. WILBUR F. PELL, Shelbyville, addressed the women physicians of Indiana dinner Tuesday evening at the Indianapolis Athletic Club.



THE ANNUAL COUNCIL DINNER was held at Stouffer's Indianapolis Inn Tuesday night.



THE HEAD TABLE at the annual Council dinner.



DR. ELI GOODMAN, Charlestown, is sketched by the artist at the North American Pharmacal booth.



DR. CHARLES FISCH, Indianapolis, lead the discussion on "Arrhythmias" at the Fireside Conferences on Cardiorespiratory Diseases Tuesday night at the Columbia Club.



SMALL COUNTY DELEGATES met early Wednesday morning in the Candidates Room of the Murat Temple.



GENERAL MEETING Wednesday morning featured speakers on Indiana University School of Medicine and its programs.



DR. HARRY SIDERYS and Dr. Erich K. Lang, both of Indianapolis, discuss one of the many entries in the Art and Hobby Show.



THE RECEPTION for members of the Fifty-Year Club was held prior to the President's Luncheon Wednesday noon.



THE HEAD TABLE at the President's Luncheon.



OVERALL picture of the crowd which attended the President's Luncheon in the Egyptian Room of the Murat Temple.



PAUL HARVEY, ABC news commentator, was the principal speaker at the luncheon.



DR. HARRY SIDERYS, Indianapolis, won first place in the scientific awards and also the Aesculapian award for his exhibit on "Medias-tinoscopy—A Practical Diagnostic Technique."



DR. WEI-PING LOH was awarded the second place award for his scientific exhibit.



THIRD PLACE AWARD in the scientific exhibits was won by Dr Robert L. Replogle, Chicago and accepted by his attendant, Helmut Kundler.



WTTV was awarded a Public Relations award for assisting the association in its "Medical Self-Help" series.



ROBERT CORYA, business editor of The Indianapolis News, won a Public Relations award for his three articles on encouraging the establishment of mental health clinics in industry.



AMA HUMANITARIAN SERVICE AWARD went to Dr. George R. Bloom, Elkhart, for his voluntary service caring for the civilian population in Vietnamese hospitals.



ANOTHER AWARD WINNER for his service in Viet Nam was Dr. Kenneth M. Lehman, Topeka.



DR. C. RICHARD BOWERS, Anderson, was also awarded the AMA Humanitarian Award for the Volunteer Physicians in Viet Nam.



DR. DALE E. CARLBERG, Jeffersonville, accepts his Humanitarian Award from Dr. Eugene S. Rifner, ISMA president.



ALSO HONORED for his volunteer service in Viet Nam was Dr. Harry L. Craig, Huntingberg.



DR. DONALD L. KERNER, Indianapolis, receives his AMA Humanitarian Award.



DR. OTIS R. BOWEN, Bremen, was given the "Service Above Self" award of the association for his work as Speaker of the House of Representatives.



THE PHYSICIAN OF THE YEAR AWARD, presented by the Mental Health Association in Indiana, went to Dr. Harry E. Klepinger, Lafayette.



DR. EUGENE S. RIFNER presents the presidential gavel to Dr. G. O. Larson, LaPorte.



PRESENTATION of the president's plaque to Dr. Eugene S. Rifner, retiring president.



THE LAST GENERAL MEETING of the convention was held Wednesday afternoon, after the President's Luncheon.



THE I.U. CLASS OF 1927 held their reunion Wednesday evening at the Athenæum.



"KING REX," Dr. Eugene S. Rifner and Mrs. Rifner greet Mr. and Mrs. Robert Robinson and Dr. and Mrs. Dwight Schuster.



A GASLIGHT girl sings in the crowd at the Gaslight Party Wednesday evening.



DR. W. L. DALTON, Shelbyville, and Dr. M. O. Scamahorn, Pittsboro, "take the pulse" of the girl in the bathtub at the Gaslight Party.



THE GASLIGHT GIRLS.



DR. RIFNER: 1966-67 president's final address to the House of Delegates Thursday morning.



DR. LARSON is sworn in as president of the ISMA by Dr. Lowell Steen, Whiting, chairman of the Council.

DR. LARSON: speaks for the first time as president.



DR. PATRICK J. V. CORCORAN, Evansville, addresses the House of Delegates after being named president-elect.

President's Address

EUGENE S. RIFNER, M.D.
Van Buren

A politician speaks of his accomplishments, but presidents of the Indiana State Medical Association walk upon the stage and speak and are heard no more. They drift out of the mainstream of action where the water runs slow. And seldom and few are those who return to the middlestream. But it behooves each and every one of them to give unto this House his experiences and his opinions. Thus we have a president's address.

Harry Truman has said that if you couldn't stand the heat to get out of the kitchen. This last year we've had a little heat. This has been our first year, first full year, under Medicare. We had the problem of the welfare, solution of those people over 65, payment under part B and the problem of assignment. We had the formation of a PAC, of which I shall speak later. And then we had the heat of the state legislature. The kitchen door is beginning to open for me and on Thursday I can walk from the heat. Already I can feel the cool breezes that come from that woods around my home. But first it is necessary that we give advice and opinions. And we shall give those today on communications, on updating of our billing, on IMPAC, Blue Shield, regional planning, AMA planning and sundry other things.

On communications, every organization has difficulty with communications, and we are not unique. But it is a shame that we have any problem whatsoever for built within our constitution and bylaws is a very method by which the grass-root man from Van Buren can speak with the president and can know what is going on. For it says there that each councilor and this is in chapter 7, section 2,

that each councilor shall be an organizer, a peacemaker and a censor for his district. He shall visit the counties in his district at least once a year, for the purpose of organizing component societies where none exist, for inquiring into the conditions of the profession and for improving and increasing the zeal of county societies and their members.

Communication a Two-Way Street

I have noticed over the years that councilors aren't very good at this. But if they were, I believe we'd have better communications. I think that councilors should go out and see the counties, learn from the counties and teach in the counties. But it hasn't always been the councilor's fault. One councilor has informed me that he has tried on two or three different occasions within a year to get a date when that county society was going to meet and he couldn't even get an answer. So communications then becomes a two-way street.

I believe that delegates should also be a line of communication. I don't believe that this House of Delegates or any previous House of Delegates has taken the message back home. I think we get caught up in the excitement of the House at the moment and then are unable to take it home, or to explain it when we get there. I would remind you of the episode of the problem of our building some seven years ago, when if one listened to the tapes, no one voted against it. But when I was back home, I could hardly find a delegate that voted for it. Now this is a lack of communications.

I believe that every delegate should be briefed by his county prior to

coming to this House and that on his return, he should be debriefed. I would request this House to ask the councilors to make visits to each county as the constitution asks him. And that the delegates be briefed and debriefed by each county. And such a recommendation should be sent to every county society.

On the up-dating of billing dues, I want to speak just a moment on this. Having been a secretary-treasurer in a small county, I realized the great problem of collecting dues, of having two or three checks from one member. I also, as a member, realize that writing a check to the county and to the district and to the state and to the AMA is a bit bothersome and a little hard on my bookkeeping. We believe that one billing, one bill, could be issued from the state. It would take the work off this secretary-treasurer who is unpaid and as a rule has no help. And those counties that are larger could use their staff for some other purpose during that time. I believe that IMPAC should be on those dues, and I would be hopeful that this House would study these resolutions. I would recommend to this House that it authorize the Executive Committee to improvise this immediately, if these resolutions are passed.

Importance of IMPAC

I should like to talk a minute about IMPAC. IMPAC was organized to be in the heart of the Indiana State Medical Association. The Executive Committee was purposely named as a part of its board, so that there would be no division of understanding, so that IMPAC would be close to the heartstrings of Indiana State Medical Association.

The Executive Committee rotates and I shall be off that board and hand my resignation in on Thursday as I step down from the presidency. I think here is an opportunity to speak and have it written into our minutes. We're going to be asked to give \$50.00 to IMPAC. What a large sum. As I look out over this group, I see many of you whom I have seen spending \$50.00 entertaining friends in one evening, and I dare say that you do this more than once a year. I doubt seriously if there are many of you who have not spent \$50.00 for a frivolous gadget on your automobile, but it seems difficult when we say we want \$50.00 to insure your freedom.

What would \$50.00 from 4,000 members do? It would give IMPAC \$400,000.00 with which to operate every biennium. What a force this would be on the political scene—much stronger than we have ever dreamed. If we could only convince the members at home; if we could show them that this is our only way. During this year I have received telephone calls and letters from men and after reading them I wondered did I pass Medicare, and can I go down and rescind it? They seem to think that it was the fault of the association. It was passed in Congress. I firmly believe that the only way we can stem the force of socialism is to elect congressmen of either party who believe in constitutional government. Health is not a right; the right is the freedom to pursue happiness and health. No government can guarantee health. You and I must guarantee freedom and the right of that pursuit by electing proper congressmen. That is where the changes will be made.

Liaison with Blue Shield

I should like to speak to Blue Shield, because over the years, there's been a lot of misunderstanding about Blue Shield. And especially the Blue Shield board. The members of the Blue Shield board, as you know, are elected from your districts. And after

he's elected, I think we should pause and understand to whom he is responsible. He then becomes responsible to the mutual members of Blue Shield. Thus he is in a position that he must protect the policy-holder. Legally he must do this. However, I see no reason why this should be in conflict with the Indiana State Medical Association at any time. For I feel that there should be no policy passed by this House of Delegates which is not in the interest of better patient care. And if all our policies are in the interest of better patient care, who can argue that this is against the members of Mutual Medical Insurance?

I believe that the liaison committee from the Council should be continued. This has been a wonderful committee, it's done a lot of hard work, and I think it should be continued. And these people should sit down and discuss their problems—not argue, we're all working for the same good. And then I would ask the Blue Shield Board members to be aware. To be aware of their close partner, Blue Cross.

A member speaking before the National Blue Cross Association has stated that he thought they should divorce themselves from Blue Shield and take over those services. Now we hear that this was just an odd member, but it was presented. Already Blue Cross in Indiana is regulating the growth of hospitals, by the sheer force of financial power. I would ask the Blue Shield board to be friendly with Blue Cross, but to watch every move they make. The Indiana State Medical Association and Blue Shield must unite in a marriage founded on the love for a common cause. This cause is the preservation of good patient care under the free enterprise system. This was the reason for founding Blue Shield. Becoming a government carrier is purely secondary and must always remain so.

Regional Planning

We have had passed just recently a regional planning bill 89-749, a new law that encompasses all medicine and all related fields. This law is so open that, if improperly implemented, it could tell you where you can practice, when you can practice, how you can practice, what kind of equipment you can have. At the present time your organization is doing its best to formulate the planning in Indiana. I would request that all members of an advisory council that comes from this membership be required to report to the Council continuously and in detail that which occurs under this law. It is dangerous; we must be on top of it. We cannot delegate this to anyone else. No one in America understands health as well as the physician, and this is what we are talking about.

One of my other observations has been the American Medical Association from our point of view as a state. I have watched other states in the short time I have been going to AMA conventions and realize that these states have a plan. They seem to plan way ahead, grooming someone for a job. I do not believe that grooming someone for a job is wrong; I could not stand here if I did. I have been groomed for this position today for seven years by such people as Robert Brown, Guy Owsley and Kenneth Neumann. I believe that in electing alternate delegates and delegates, we should weigh in the balance where these people can go in AMA, what influence they will have and whether or not the young could not be instructed there so that they would be better delegates when their turn to serve came.

I would ask that the future planning committee and the Council sit down and work out goals for Indiana. I am not so shy as to believe that we could not elect an AMA president from Indiana, but we cannot elect a president if we do not plan for it. We can't suddenly decide that someone is that strong. Now I have scolded

every one in the room. So it is high time that I did it to myself.

And in closing I should like to read to you a portion of the 11th Medical Councilor District report, printed in *The Journal* on page 1218, and delivered May 17, 1961. It was the first speech I gave in organized medicine, above the county level. And as I read it the other night, I was a little chagrined to find out that I had accomplished so little in my stay. For it applies as well today as it did in 1961. And this is an excerpt from the speech:

"Constantly within the doctors' room at the hospital, at meetings, at parties where physicians gather, we hear the remark that the Indiana State Medical Association is wrong, and opposed to this and opposed to that, and that it never does anything but squabble and it's run by a few of the hierarchy.

AMA Planning

"We hear the same thing of the American Medical Association. In all I am very proud to hear that those who run the American Medical Association are 100 years behind the socialistic trends of today, for I hear that they are 100 years behind the times. I am glad to hear that they are from an era where people wanted to fight for the Union, where people were proud of the rights and privileges of this great country and were not asking this great country to support them, but only asked that it be a strong and wonderful nation made up of free people.

"I wonder why these organizations are as corrupt as my fellow physicians would have me believe; why it is that they are such? And in thinking about this I come across the idea of who makes up this organization. I am very upset to find out that I am one of the members and that you are one of the members. I wonder why it is that everyone speaks of the old doctor, the old country doctor and then gives a rather scathing remark concerning you and I. I think it is

rather simple. Today we are noted for what? To turn patients away by the hundreds, without any sympathy, filled with wonder drugs which would have made our forefathers most envious, but completely empty of compassion, of love and of service to our fellow men. Old Doc wasn't noted for his wonder drugs—he was noted for his devotion to duty, for his thoughtfulness concerning his patients, for his love of his fellow men, for his willingness to sacrifice himself if necessary for them. I'm afraid that many of us are not so noted.

"It is high time that we look back 100 years in the practice of medicine and try to glean from that era that which placed the doctor with a little black bag upon a pedestal, that which made him the man of honor within his community, that which made him the man of integrity whose word was nearly law. What placed him there? How did he tumble from this high position? What gnawed at the pedestal until it crumbled? Was it the public? Was it the socialistic tendencies of our times? No, I'm afraid it was not. I'm afraid that those who sought to climb it began to eat away at its base, finding its chunks were better at the time, and that they would rather take a piece of rock from the bottom than to climb to the summit. And in gleaning their financial rewards, and in hurrying and scurrying, they forgot the patients.

"So today you and I fight a battle against socialism because we forgot the patients. Oh, it is true that socialism is here in many other fields, but

these too did likewise. It is high time that we returned to the visions we had before and during medical school where most of us thought we would be fine and honored gentlemen, serving humanity without regard to our own personal benefit nor our own personal health nor wealth. Today we return and find so few devoted. Is not this the reason we are in trouble? Would it not be well if each and every man, woman and child in the United States could turn to you and say, 'He is *my* doctor' and mean it.

"Have we in so many short years, approximately 200, forgotten the reason the pilgrims landed on the Eastern shores of this great country? Have we as physicians in a much shorter time perhaps, 10, 20, 30 or 40 years, forgotten why we obtained a diploma stating that we were doctors of medicine? As I look on the national scene, it took some 200 years for socialistic changes. For some of us it has taken but a few. Let us return home from this meeting, dedicated to the care of the injured and the sick, with a certain feeling for our fellow men and let us put together the pedestal upon which our profession stood, by building it with the stones of human kindness, love, affection, service and devotion to duty which our forefathers had.

"And in this respect we shall build a strong profession which no man can cast asunder."

Is not this just as applicable today as it was in 1961?

Thank you. ◀



Address to the House of Delegates

G. O. LARSON, M.D.

LaPorte

THE Gallup organization has made a fascinating new survey of some 3,000 typical young Americans, a survey commissioned by *The Saturday Evening Post*. It shows most clearly that far too many of our boys and girls have a curiously flabby and uninformed attitude about our country, its history, and its future, and about their own lives and futures. Too many are interested chiefly in security, an eight-hour day and a relatively easy way of life. If the spark of ambition is there, it is buried very deep in some of them.

As one rises to the chair of the presidency of this association, after many years of labor on its various committees and councils, one begins to wonder if the same results may not be true of our own profession if such a poll were taken today.

The hustle and bustle of our fast moving lives, the pressures of our present economy, and the transition of time, I fear, have served to give many of us a curiously flabby and uninformative attitude about our profession, its history, and its future.

Organizational Meeting

It was just 118 years ago this last June sixth that 28 physicians in the state of Indiana met in Indianapolis for the purpose of organizing what we know today as the Indiana State Medical Association.

At that time, the report of the committee to draft the constitution contained three points:

1. The association of the profession for the purpose of mutual recognition and fellowship.
2. The maintenance of union, harmony and good government among its members thereby promoting the interests, honor

and usefulness of the profession.

3. The cultivation and advancement of medical science and literature and the elevation of the standards of professional education.

Also at this organizational meeting, those 28 doctors took some definite steps in the interest of public health. They asked and adopted a memorializing resolution directed to the Governor and the State Legislature of our state for the establishment of a law requiring that in all cases where the plea of insanity is set up as an excuse for a crime, the question of insanity shall be first and separately tried and decided by a Commission on Lunacy. This is a practice still going on today. They determined they needed a medical journal for the dissemination of scientific information to the doctors in the new state of Indiana. They also adopted a resolution asking the legislature to pass a law for the recording of births, deaths and marriages.

As one reviews the transactions of this organization since the year 1849, one sees a constant stream of resolutions adopted by the profession of this state which enhance the public health and well being of the citizens of our great state.

Sometimes I hear the remark today, well, why do we have a medical association, and then one thinks back as to why they had an association in 1849. Why did these 28 men come together for the purpose of organizing a medical association in the state of Indiana?

There were many. In those days, communications were not available that we are accustomed to and take for granted in our present life. There

were no journals; there were no scientific publications; there were no specialty organizations; there were no district medical societies and county medical societies as we know them now; therefore, these men had a burning desire to bring themselves together for an exchange of scientific information which would help them to practice better medicine and thereby make the people of our state a healthier and more invigorating class. It was difficult in those days to come together because the transportation was not as convenient as we are accustomed to now.

Those men of 118 years ago made extreme sacrifices for the purpose of developing the standards of the profession and the enhancement of the profession in the eyes of the public. They worked tirelessly to develop many of the things we benefit from today.

Then one takes a fast trip to the proceedings of this association in 1867—just 100 years ago. It is interesting to note that one member was read out of the society for plagiarism for having delivered a paper at the preceding convention which was an exact copy of a paper delivered by another physician in another state. Enforcement of ethics was one of the stalwart principles of the association 100 years ago.

Establishing a Medical School

But perhaps of more interest is the fact that 100 years ago the convention of the association was very involved in adopting motions and resolutions for the establishment of a medical school in the state of Indiana. The president, Dr. Vierling Kersey of Richmond, Indiana, in his speech before the Association, said,

"We are also without a medical school in the state—a fact to be seen only in the light of rare good fortune. Not that medical schools are to be regarded with aversion. Far otherwise. If there be institutions in our country, around which the pleasant memories of the profession cluster and love to linger, they are our medical schools. If there be names embalmed in the incense of youthful gratitude and veneration, maintaining fresh and unabated through life their magic power to warm and stir the spirit, they are the names of our distinguished teachers—Warren, Chapman, Mott, Dunglison, Bell, Mussey, Locke. Though nearly all retired to the inner temple, they are still in our midst and shrine and memory—elate, flush, animate—the living impersonations of eloquence, genius, learning and worth. May the halo about them never be lifted!

"But what do we want with a medical school in Indiana? Surely nothing, unless it be established on a scale and basis to compete in excellence, in eminence, in every appliance and means of instruction, with the very first schools of the age. It should assume at once a high rank among our positive luxuries, for it could not possibly be regarded in the light of a necessary institution. It should be richly endowed, placing it quite beyond the influence of pecuniary considerations, and thus commanding teachers of the first order—vigilant guardians of professional character; providing against unworthy membership, by enrolling only those of unquestionable fitness, and conferring degrees on merit alone. Such an institution will be welcome whenever it comes.

"But a medical school destined to struggle for bare existence, constrained to admit every applicant, merely for the pittance he pays; capable of competition mainly in the cheapness of its own teachings, and its facility in conferring degrees bearing little significance as testimonials of merit — such an institution would

unquestionably prove an essential calamity to the profession and people of the state, transient enough, no doubt, as a medical school, but more enduring as a monument of professional indiscretion.

"When physicians in their private capacity, and teachers of medical schools, shall come to an adequate realization of the fact that we are, each and all, in the position, ex-officio, of guardians, in limine, of the profession; that we are responsible before heaven and in the eyes of men, for its shortcomings in capability, sterling intelligence, and usefulness to mankind; and when we become careful to discharge the various obligations of this high trust with fidelity and integrity—then may we look for the dawning of our day. But while reckless indifference to these living interests and sacred obligations reign rampant, regardless of rank in the profession, may nemesis go on, as she inevitably will, serenely heedless of the deprecation, distributing the full measure of her righteous penalties inexorably, relentlessly, inflexibly."

By adopting this action, the Indiana State Medical Association therefore can take credit today for the activity which lead to the establishment of a medical school which is now the Indiana University School of Medicine.

Many other notable advances have been made by activities of this association. For example, sponsoring the first Food and Drug Act in the nation which later became the model for the Federal Food and Drug Act. The association also had a heavy hand in bringing into being what we now know as the Indiana State Board of Health.

I can recite many other important contributions which have been made by the efforts of this association for the welfare of the public of our state. But time will not permit.

Problem of Communications

History is history and history is

yet to be written so therefore let us talk about our future. Today with our involvement and our many activities, we face a serious problem of communications—a method of communication to bring to the individual member the full and complete understanding of the problem with which his organization is concerned and with which he should be concerned.

We have established in this state a system of medical districts, yet I have seen our districts hold elections for councilors of our association with less than one percent of the membership in attendance. This is a deplorable situation when these meetings are for the purpose of the physicians of the various districts of our state electing their leadership which controls their destiny through the activities of their association.

Perhaps our district meeting, as we have known it in the past, is outdated. Some of us in my own district, the 13th, felt that we would try an experiment this year and devoted most of our program to the matters of socio-economics. We had Doctor Ernest B. Howard discuss with us many of the laws and activities of the Congress that have a direct bearing upon our practice of medicine. We asked Mr. Robinson of our association to discuss with us those conditions and provisions of the bill known as the "Comprehensive Health Planning Act" and our illustrious president, Doctor Rifner, to talk to us about sticking together with a cohesiveness we must have if we are to survive. Perhaps at this time we should re-think our district activities and try to make them of sufficient interest so that we will get a large representation of our membership out for these very important meetings.

Several years ago we condensed some 60 committees into about 12 commissions in order to try to get full understanding and exchange of information between the state association committees and the various component societies. It was decided

that each medical district would have a representative on each of these commissions. The philosophy of this idea was that the district representative on the various commissions of the association would in effect serve as a district chairman for these activities and respective medical districts. It was hoped he would be responsible for meeting with like members from the county medical societies in the district, to discuss the thinking of the state commissions and at the same time to solicit suggestions from county societies as to steps which we might take in further strengthening the organization and activities of our association.

This has not been done with any degree of effectiveness and I hope that during my tenure as president of your association, we can see this philosophy fully implemented and thereby, we may have a free exchange of information between the component societies, the district societies and your state association.

We need the participation of all, if we are to program our activities and to develop policies which will not only benefit our profession but also the well being of the people of our state.

We must develop within our state those men who have a sincere interest and desire to be effective in the organization. We need ideas. We need research in depth on the problems we face in order that these commissions and committees may make appropriate recommendations to this House for their consideration. We can no longer afford to stand still. We must either go forward or backward. It is up to us to set the course which we will take.

Specialty Organizations

I would hope to see during my year as president the various specialty organizations of the state meet with us to discuss the feasibility and possibility of their secretarial offices being located in the building of the Indiana State Medical Association. I believe we can offer them secretarial

services in an efficient and perhaps more economic manner. I also feel that this would bring about a closer relationship between these organizations and the Indiana State Medical Association, a relationship that must be nurtured and improved if we are to succeed.

I would like to see instituted in my year as president a renewal of the annual conference of county medical society officers. I feel in this day we need a complete exchange of information between your state officers and those of the county societies in order that all of us may better plan and carry out our responsibilities to the members of our profession.

I would hope that every member of this association would some time during the year make it a point to visit our association headquarters and learn first hand of the tremendous amount of work that is carried on in our association offices. It is almost unbelievable and impossible for the average physician to have the slightest concept of the amount of work which is done in our behalf by our association staff. Yet it is probably one of the smallest staffs for the size of the association in the country.

Computerized System

We are now living in a computerized age and with this, of course, comes the necessity for the association to seriously consider getting into the computerized field in many of our activities.

You have heard others, and you will see resolutions calling for the authorization by this House of Delegates for the Council to install a computerized system for the billing of dues. It is our belief that this will greatly simplify the handling of dues for the members and for the busy physician who is secretary of the county medical societies. If the House agrees with the proposal which you will have before you for your consideration, then it will be possible for the association to send each physician in the state of Indiana a bill for his county, district, state and AMA dues

and he in turn will write only one check rather than two or three that are presently required. The state office will then distribute the funds to the county, district and AMA with the computerized report of each member and the amount of his contribution to the respective societies.

We believe this would be a more efficient way to facilitate the collection of dues and would make it easier on the practicing physician and partially relieve him from his burdens of secretarial duties at the local level. At the same time, it would make it easier for the physician to pay his dues for county, state and district societies. Also, we are proposing that we put an item on the billing for the voluntary, non-tax deductible contribution to our PAC organization known as IMPAC.

I seriously urge that you approve this recommendation. The activity of our political education group the past years is already showing proof of success for our profession. By increased participation of the membership in this activity, we can do much more in selecting and supporting candidates who believe as we do—in the constitutional form of government. Health has been the target of Congress for the past several years and will continue to be the target for legislation in the coming sessions, therefore it behooves us to be prepared to help select and elect men who have a feeling for a constitutional type of government and recognize the important advances made by the yet unregimented medical profession. Too, while laws are passed at congressional level, they must be implemented at the state legislature level. Therefore, we must be strong enough and active enough to get in these races and help select those who will be favorable to our profession and who will be interested in doing the best for the health of the people of our state.

Therefore, I urge you to support these recommendations that will come before you in these areas. I would

urge you to go back home and interpret and work for implementation of these programs once you have approved them. There is a fundamental point that needs to be established if medicine, and indeed the whole structure of our society as we know it, is to survive and that is that there is nothing sinful, wrong, or underhanded about an individual or an organization becoming involved in the business of running this country. It is not only wrong, but it is inexcusable to avoid this responsibility.

For too long a time we sat back with a "holier than thou pose" and said that we're not interested in politics—we just want to practice medicine. It doesn't take much of a political genius to see what has happened when the majority of us adopted that philosophy.

Justice Oliver Wendell Holmes once said, "It is required of a man that he should share the action and passion of his time at peril of being judged not to have lived." I agree most

wholeheartedly with those sentiments, gentlemen. The first and foremost duty of every one in this room is to be a good citizen and this requires active participation in your government and its activities. This is one of the prices we must pay if we are to continue to enjoy freedom and democracy.

When one of the eldest American statesmen, Benjamin Franklin, was leaving the Constitutional Convention, it is said that a lady from Philadelphia approached him and asked the old gentleman what the delegates had given them there. His reply was, "We have given you a Republic, madam, if you can keep it."

And so you must be eternally involved in the process to make freedom work and we should rejoice in the opportunity to do so. Let us begin by demolishing those old cliches that say, "Medicine doesn't belong in politics" or "I don't think we should get involved."

Gentlemen, we are involved—right

up to our ischial tuberosities—make no mistake about that. Every one of you that is apathetic to this problem is doing a vast disservice to progeny and to the future generations of this country. Please observe, I did not say that you were all these vile things if you don't happen to share my particular political beliefs, but you are extremely derelict if you are neuter in the matter of politics. This is not the day and age for political eunuchs.

I thank you for the honor which you have bestowed upon me and promise you to do my utmost to carry out the responsibilities in the way in which you expect. I would hope that I have our cooperation, your understanding and your help and would invite you at any time to correspond with me, setting forth your ideas and philosophies in order what we might strengthen and make our organization a better and more useful organization. Thank you. ◀

HARDING HOSPITAL

WORTHINGTON, OHIO

A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

THE HARDING HOSPITAL PROVIDES:

- * 125 In-patient beds —
- * Day Hospital program —
- * Full time attending staff of psychiatrists —
- * Professionally trained Adjunctive Therapy staff with programs in occupational, recreational and vocational therapy. (Crafts, Fine Arts, Greenhouse, etc.)
- * Qualified staff of psychologists —
- * Social Service department —
- * Consultation and evaluation for out-patients.

For particulars on rates and terms or on specific patients write or call —

Harding Hospital - Worthington, Ohio
Area Code 614 - 885-5381

George T. Harding, M.D.
Medical Director

James L. Hagle
Administrator

The Student American Medical Association

BARTH A. GREEN, A.B.

President, Student AMA

Indianapolis*

MR. President, members of the House of Delegates, and honored guests: I would like first of all to thank you for inviting me to attend your meeting, but, because I have been quite busy as a neurosurgeon this month, I was not able to prepare a speech. I would like to tell you briefly what the Student American Medical Association is, what it does, what it stands for, and whom it represents.

The Student American Medical Association is a national organization divided into seven regions, which include 95% of the medical schools in the United States, Canada and Puerto Rico. On a local level, Indiana has one of the largest and most active chapters in the nation and is the only organization representing the students on our campus.

National SAMA is an extremely active and aware organization which coordinates the program and activities of the various regions and individual chapters. An annual convention is held each spring, and representatives of each of the member schools voice their opinions on various issues concerning medical education, medical trends, politics and the role of the medical student in our society. Some of the issues discussed at the last convention included Medicare; Medicaid; abortion laws; federal loans for medical students; birth control; the female doctor draft; our part in the Vietnamese war; new medical curricula; wages and status of interns, residents, and other house staff; and programs to improve public health at local levels. There was much heated debate on these issues with opinions varying

sharply with the geographical areas. At one point, the issue of the morality of the Vietnamese war prompted two of the California organizations to drop out temporarily because of the reluctance of the national organization to denounce publicly the war as immoral. Finally, compromise resolutions are passed and are put in record as opinions of the assembly. This year's group favored liberalized abortion laws, implementation of widespread birth control programs, female draft, minimum wage for interns and residents and various other resolutions.

An Active Organization

The national organization publishes a monthly magazine which is mailed to the organization's medical student, intern, and resident members. It includes internship, externship, residency, and practice opportunities; scientific articles, directed especially toward the students; problems that modern medicine faces; various quizzes and examinations which challenge the student in all areas of study; and editorial articles which discuss the present issues confronting the medical student in our society.

The national organization also has originated programs such as the intern-matching program, which now enjoys nationwide use, and the European externship program, scholarship programs, loan programs, and insurance programs, all directed toward making life a little more enjoyable for the student. The newest program being planned is the IRS Program, which will start next August in Chicago. This is a mass seminar of hundreds of representatives from hospitals across the country where junior and senior medical students will be able to be interviewed

and select good internship and residency programs without extensive travel and great expense, which for most students is financially and time-wise quite impracticable.

On the local level, Indiana's chapter is run by a SAMA Council of 32, composed of eight representatives from each class. This Council meets once a month and directs the various activities of the organization. It is felt that one of the main problems facing Indiana medicine today is the relatively small percent of Indiana University School of Medicine graduates who stay in the state for postgraduate training and eventually practice medicine here. To help alleviate this trend, we have directed many programs toward exposing students from the Indiana University Medical Center to the great opportunities that do exist in externship and postgraduate medical training here in Indiana. Two summers ago I enjoyed such an externship at Gary Methodist Hospital to the extent that I probably will choose that area to hang my shingle.

Preceptorship Program

The program you are probably most familiar with is the one-day preceptorship program which was started in 1966 and which has now been adopted by most chapters across the nation. We sent letters to all the members of your organization and received gratifying responses. The students shared your enthusiasm and the program was a success. This year we are again hoping for a large participation. Last year students spent a day with many of you and found out what type of medicine you practice and what your individual areas have to offer and then came back to their classmates with nothing but

* Speech presented before the ISMA House of Delegates, October 9, 1967. Mr. Green is a junior medical student at the I.U. Medical Center.

praise for you and the program. Through this and other efforts, including curriculum changes by the medical school, I think the trend to leave the state will soon reverse itself.

Some of the other activities of our chapter include the high school visitation program wherein we endeavor to counsel the high school seniors aspiring to a career in medicine and try to prevent their making the countless errors we all have probably experienced. We also run a series of noon movies which we try to correlate with the curriculum of our freshmen and sophomores; we also have a lecture series with speakers from all over the nation. These movies and speeches are not all academic but include such controversial subjects as socialized medicine and the doctor's draft.

Among the things our chapter offers to its members is a local scholarship and loan fund, whereby

short-term, no-interest loans provide much-needed dollars to any medical student with no questions asked. Our social program includes dances, picnics and outings, and our athletic program includes inter-class basketball and football tournaments, which are highlighted by a student-faculty game.

We also maintain liaison with the American Medical Association, the Indiana State Medical Association, the Marion County Medical Society, the American Academy of General Practice, and the Indiana University School of Law, with whom we hold mock jurisprudence trials.

Medical students are a quite active, vigorous group of people these days. Our frequent role changes throw us into tremendous confusion at times. Our first two years we are strictly students who do little else but try to digest a vast amount of material and absorb a completely new and extensive vocabulary. Then over-

night, we are suddenly called "doctors" by nurses and patients, even though we ourselves know better, as we work with and treat patients, always with the guiding hand of experience. Then suddenly we are "real doctors", and instead of being greeted by all as healers and dedicated people who have put in 100-hour work-weeks in school and during training, we are confronted with antagonistic feelings by many who consider us money-hungry, inhuman, cold and calculated. We do not want to have this image but we also are an independent group of people who have been taught to think for ourselves, and we cannot tolerate an iron-sleeve control of our activities. This is our dilemma and we hope that time will answer our confusion, along with guidance from our consciences and our colleagues.

Thank you very much. ◀

Tour AMA Headquarters

Planning to be in Chicago in the foreseeable future? Then why not take time out from your vacation or professional schedule to visit AMA headquarters.

Physicians, their wives and guests are welcome to visit the building, located at 535 North Dearborn just north of the Loop, anytime during office hours—8:30 to 4:45 Monday through Friday—for a 45-minute guided tour of the nine-floor building and its offices.

Tours are conducted by specially trained headquarters employees, who seek to acquaint visitors with the organizational structure of the AMA, major areas of activity and many of the services available to physicians and the public.

To arrange a tour in advance, just write Miss Patti Chapman, director of the AMA's Tour Guide program, at the Program Services Department. If advance notice is not possible, just report at the reception desk that you desire to have a tour of the building.

Convention Election Results:

Dr. Patrick J. V. Corcoran is Named President-Elect

Dr. Patrick J. V. Corcoran, Evansville internist, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October.

Dr. Corcoran has practiced in Evansville since 1943. He received his medical degree from Northwestern University Medical School in 1938, and his masters degree in internal medicine from St. Louis University School of Medicine in 1943, following a three-year fellowship in internal medicine at St. Louis. In 1948, he was certified by the American Board of Internal Medicine.

Dr. Corcoran was in his second three-year term as First District councilor for ISMA and has been a member of the Vanderburgh County Medical Society since 1944. He served as president of the county medical society in 1958 and was a former member of the ISMA Commission on Legislation.

Dr. Corcoran has been president of St. Mary's Hospital medical staff and chief of the medical section there. He currently is serving his third term on the City-County Health Board in Evansville, and has been active in health organizations concerned with heart disease and cancer.

Also taking office during the convention were Drs. Lester H. Hoyt, Indianapolis, elected treasurer; M. O. Scamahorn, Pittsboro, elected assistant treasurer and Lowell H. Steen, Whiting, re-elected chairman of the Council. Dr. Ralph V. Everly, Indianapolis, was re-elected chairman of the Executive Committee and Dr. Burton E. Kintner, Elkhart, was re-elected to the Executive Committee.

Drs. Guy A. Owsley, Hartford City,

and Jack E. Shields, Brownstown, were re-elected to the posts of delegates to the American Medical Association for a two-year term beginning December 31, 1967, and Drs. Maurice E. Glock, Fort Wayne, and Dwight Schuster, Indianapolis, were named alternates. Dr. Don Wood, Indianapolis, was elected alternate to replace Dr. James A. Gosman, Indianapolis, who resigned. Other delegates who will represent ISMA and whose terms expire in December, 1968, are: Drs. Harold C. Ochsner, Indianapolis; Eugene F. Senseny, Fort Wayne and Frank H. Green, Rushville. Their alternates are Drs. Wood, Robert M. Brown, Marion and Kenneth O. Neumann, Lafayette.

Taking over their official duties as new councilors for their districts at the convention were Drs. Stephen Smith, Knightstown, Sixth District and Dr. William R. Clark, Fort Wayne, Twelfth District. Dr. Donald M. Kerr, Bedford, Third District councilor and Dr. Peter R. Petrich, Attica, Ninth District councilor, were re-elected. Dr. Frederic Schoen, Fort Wayne, was elected alternate councilor for the Twelfth District.

Results of the various section elections are as follows:

Section on Surgery: Chairman—Donald M. Schlegel, Indianapolis; Vice-chairman—Henry Larzelere, Marion; Secretary—Austin Gardner, Indianapolis.

Section on Internal Medicine: Chairman—I. E. Michael, Indianapolis; Vice-chairman—Louis Sandock, South Bend; Secretary—Robert E. Rudesill, Indianapolis.

Section on Ophthalmology and Otolaryngology: Chairman—M. Richard Harding, Indianapolis; Vice-chairman, David E. Brown, Indianapolis; Secretary—George A. Clark, Indianapolis.

Section on Anesthesiology: Chairman—William M. Matthews, Indianapolis; Vice-chairman—Merle E. Pickett, Fort Wayne; Secretary—Jerry R. Miller, Indianapolis.

Section on General Practice: Chairman—Jay Reese, Martinsville; Vice-chairman—Robert Mouser, Indianapolis; Secretary—Richard Juergens, Fort Wayne.

Section on Obstetrics and Gynecology: Chairman—Robert M. Reid, Columbus; Vice-chairman—Tom W. Wachob, Jr., Kokomo; Secretary—Charles R. Echt, Indianapolis.

Section on Public Health and Preventive Medicine: Chairman—Donald M. Kerr, Bedford; Secretary—Henry G. Nester, Indianapolis.

Section on Radiology: Chairman—Richard A. Silver, Indianapolis; Vice-chairman—John A. Robb, Indianapolis; Secretary—Edwin F. Koch, Jr., Muncie.

Section on Nervous and Mental Diseases: Chairman—Gordon T. Brown, Indianapolis; Vice-chairman—James E. Benson, Elkhart; Secretary—Wesley A. Kissel, Indianapolis.

Section on Pathology: Chairman—Robert J. Frost, Michigan City; Secretary—Robert L. Costin, Indianapolis.

Section on Pediatrics: Chairman—Roland E. Miller, Lafayette; Vice-chairman—Gustaf W. Erickson, South Bend; Secretary—Morris Green, Indianapolis. ◀

THE WINNERS—118th Annual Convention

Indianapolis, Oct. 9-12, 1967

MEN'S ART AND HOBBY SHOW

Oil Painting:

First: L. Paul Hart, M.D., Evansville
Second: Dr. Hart, Evansville
Third: T. T. Suzuki, M.D., Covington

Honorable Mention:

Ray Burnikel, M.D., Evansville
Charles P. Schneider, M.D., Evansville

Watercolor Painting:

First: W. L. Harlan, M.D., Evansville
Second: Dr. Harlan, Evansville
Third: Dr. Harlan, Evansville

Honorable Mention:

Dr. Harlan, Evansville

Drawing:

First: W. L. Harlan, M.D., Evansville

Photograph — Black and White:

First: Walter A. Dycus, M.D., Evansville
Second: Dr. Dycus, Evansville
Third: Dr. Dycus, Evansville

Honorable Mention:

Dr. Dycus, Evansville

Photograph — Color:

First: Truman Caylor, M.D., Bluffton
Second: Dr. Caylor, Bluffton
Third: Richard B. Hovda, M.D., Evansville

Sculpture:

Boyd K. Black, M.D., Vincennes

Craft:

First: William S. Robertson, M.D., Spiceland
Second: Dr. Robertson, Spiceland

Special Exhibit:

First: Robert Arendell, M.D., Evansville

WOMAN'S AUXILIARY ART AND HOBBY SHOW

Oil Painting:

First: Mrs. Nicholas Egnatz, Munster
Second: Mrs. Boyd K. Black, Vincennes
Third: Mrs. Garvey B. Bowers, Kokomo

Honorable Mention:

Mrs. John D. Wilson, Evansville
Mrs. Robert Arendell, Evansville

Crafts:

First: Mrs. Joseph Guckien, Evansville
Second: Mrs. Ray Burnikel, Evansville
Third: Mrs. William S. Robertson, Spiceland

Honorable Mention:

Mrs. C. C. Young, Evansville
Mrs. Garvey Bowers, Kokomo
Mrs. Ray Burnikel, Evansville

SCIENTIFIC EXHIBIT AWARD WINNERS

Award No. 1 — Harry Siderys, M.D., John N. Pittman, M.D., Methodist Hospital Graduate Medical Center, Indianapolis — MEDIASTINOSCOPY — A PRACTICAL DIAGNOSTIC TECHNIQUE

(Dr. Siderys also was awarded the Aesculapian certificate and cash award of \$200.00, donated by Mead Johnson Laboratories)

Award No. 2 — Wei-Ping Loh, M.D., chief pathologist; A. S. Williams, M.D., Coroner, Office of the Lake County Coroner, Gary — TRAFFIC DEATHS IN LAKE COUNTY.

Award No. 3 — Robert L. Replogle, M.D., University of Chicago School of Medicine, Chicago — PREVENTION OF POSTOPERATIVE INTESTINAL ADHESIONS — EXPERIMENTAL AND CLINICAL STUDIES

MEN'S GOLF TOURNAMENT

Low Gross — Joseph Karlick, M.D., Arcadia

Low Net — Thomas W. Johnson, M.D., Indianapolis

Bankers Handicap — R. C. Stone, M.D., Ligonier

Longest Drive — Edward C. Shipley, M.D., Indianapolis

Closest to Pin — William B. Lybrook, Jr., M.D., Indianapolis

Highest Score — Warren N. McClure, M.D., Kokomo

Minutes of the House of Delegates

1967

CREDENTIALS COMMITTEE REPORTS	1758	REFERENCE COMMITTEE NO. 3	1767
		Resolution No. 4	1768
IN MEMORIAM	1758	Resolution No. 6	1768
		Resolution No. 17	1768
1966 MINUTES	1759	Resolution No. 19	1768
		Resolution No. 5	1769
1967 REFERENCE COMMITTEES	1759	Resolution No. 21	1769
		Resolution No. 8	1770
AMENDMENTS TO CONSTITUTION	1759	Resolution No. 18	1770
		Report of Chairman of Blue Shield	
NEW BUSINESS	1760	Board of Directors	1770
		Legislation	1770
REFERENCE COMMITTEE NO. 1	1760	Medical Economics and Insurance	1771
Voluntary Health Agencies	1760		
Public Health	1760	REFERENCE COMMITTEE NO. 4	1771
Inter-Professional Relations	1760	President's Address	1771
Supplemental Report of Commission on Inter- Professional Relations	1761	President-elect's Address	1771
Aging	1761	Report of Executive Secretary	1771
Grievance Committee	1761	Report of Treasurer	1771
Resolution No. 2	1761	Report of Chairman of Council	1771
Resolution No. 15	1761	Reports of Councilors	1771
Resolution No. 20	1761	Report of Editor of The Journal	1771
Resolution No. 23	1761	Report of Delegates to AMA	1772
Resolution No. 26	1762	Woman's Auxiliary Presidential Address	1772
Resolution No. 27	1762	Executive Committee Report	1772
Resolution No. 29	1762	Report of Indiana Student AMA	1772
Resolution No. 32	1763	Constitution and Bylaws	1773
		Future Planning Committee	1773
REFERENCE COMMITTEE NO. 2	1763	Resolution No. 9	1773
Medical Education and Licensure	1764	Resolution No. 11	1773
Special Activities	1764	Resolution No. 25	1773
Governmental Medical Services	1764	Resolution No. 12	1774
Student Loan Committee	1764	Resolution No. 16	1774
Convention Arrangements	1764	Resolution No. 24	1774
Maternal Mortality Study Report	1764	Resolution No. 30	1775
State Board of Medical Registration and Examination Report	1765		
Resolution No. 1	1765	ELECTION OF OFFICERS	1775
Resolution No. 3	1765	ADDRESS OF PRESIDENT-ELECT	1775
Resolution No. 7	1766		
Resolution No. 10	1766	PLACES OF FUTURE ANNUAL CONVENTIONS	1775
Resolution No. 13	1767		
Resolution No. 14	1767	OATH OF OFFICE	1775
Resolution No. 31	1767	RESOLUTIONS OF APPRECIATION	1775
		ADJOURNMENT	1775

House of Delegates Proceedings

INDIANAPOLIS SESSION

October 9-12, 1967

The House of Delegates convened at 2:00 p.m., Monday, October 9, 1967, in the Ballroom of the Columbia Club, and again at 9:00 a.m., Thursday, October 12, 1967, in the Ballroom of the Columbia Club, Indianapolis. Dr. G. O. Larson, president-elect, called the first meeting to order and presided until Dr. Eugene S. Rifner, the president, delivered his presidential address. Dr. Rifner and Dr. Larson presided at the final meeting of the House on October 12.

Dr. Lowell W. Painter gave the invocation at the first meeting.

Credentials Committee Reports

On motion of several, duly seconded, attendance slips signed by the delegates were accepted in lieu of a roll call at the first meeting. Dr. T. Neal Petry, chairman of the Credentials Committee, reported 102 delegates, eight past presidents, 12 councilors, five alternate councilors, the president, the president-elect, the assistant treasurer, one AMA trustee, two delegates to the AMA, the editor of *The Journal*, and 15 guests present at this meeting.

At the second meeting, on motion of many, duly seconded, put to vote and carried, attendance slips signed by the delegates constituted the roll call and registered the following present: 95 delegates, six past presidents, 12 councilors, four alternate councilors, the president, the president-elect, the assistant treasurer, one AMA trustee, three delegates to the AMA, the editor of *The Journal*, and 13 guests.

According to Chapter IV, Section 3, of the Bylaws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The chairman made the following announcements:

1. The Bylaws may be amended at any annual convention by a majority vote of all the delegates present at that convention, after the amendment has laid on the table for one day. (Chapter XXXII, Section 1, Bylaws).

2. The House of Delegates may amend any article of the Constitution by a two-thirds vote of the delegates present at any annual convention, provided that such amendment shall have been presented in

open meeting at the previous annual convention and that it shall have been published twice during the year in *The Journal* of this association. (Article XIV, Constitution.)

3. The meetings of this House of Delegates will operate on Robert's Rules of Order.

4. On any question that is before the House, any member of the House has a right to call for a division of the House.

In Memoriam

The House stood in silence a moment in tribute to those members of the association who had served as members of the House of Delegates, or in an official capacity in the association, who had passed away since the last meeting of the House in October, 1966:

L. HOWARD ALLEN, Bedford. Secretary, Lawrence County Medical Society, 1931-37; member, Committee for the Study of Puerperal Mortality, 1933-36; Inter-Professional Health Council, 1941-43; Committee on Public Policy and Legislation, 1950; Physician-Hospital Relations Committee, 1954; vice-chairman, 1950 and 1953, and chairman, 1951, Section on Obstetrics and Gynecology.

ERNEST O. ASHER, Indianapolis. Delegate, Marion County, 1934-41; chairman, Committee for the Study of Puerperal Mortality, 1934-35; member, Committee on Expert Testimony, 1935; chairman, State Division of Public Health Liaison Committee to Deal with Social Security, 1936-40; member, Liaison Committee with Indiana State Department of Public Welfare, 1939-40; member, Executive Committee, 1941-43; chairman, Advisory Committee to Bureau of Maternal and Child Health of Indiana State Board of Health, 1941; acting chairman, 1942, and chairman, 1943-44, Medical Relief Committee.

MAURICE J. BARRY, Indianapolis. Member, Committee on Graduate Education, 1934-35.

GEORGE W. BOWMAN, Indianapolis. Member, 1945, and chairman, 1953, Committee on Venereal Disease.

JOHN R. BRAYTON, Indianapolis. Member, Medical Economics Committee, 1945, and Auditing Committee, 1954.

ELTON R. CLARKE, Kokomo. Secretary, Howard County Medical Society,

1928-29, 1944-45; member, Committee on Secretaries' Conference, 1929; delegate, Howard County, 1944, 1946-48; member, Committee on Necrology and History, 1945-48; councilor, Eleventh District, Dec., 1948-Nov., 1955, and chairman of Council, Jan., 1953-Nov., 1955; member, Committee on Crippled Children Services, 1949; Executive Committee, 1953, 1956-57; chairman, Anti-national Health Insurance Committee, 1953, and Auditing Committee, 1954-56; president, Indiana State Medical Association, 1957; member, Indiana Inter-Professional Health Council, 1957; ex-officio member, Liaison Committee with American Legion, Hospital Association and Dental Association, 1957; Student Loan Committee, 1957; chairman, 1958, and member, 1959-63, Commission on Medical Education and Licensure; member, Grievance Committee, 1958-60.

WILLIAM L. DAVES, Evansville. Member, Committee on Industrial Health, 1950; president, Vanderburgh County Medical Society, 1956; member, Committee on Medical Education and Licensure, 1956-57; Committee on Convention Arrangements, 1957.

FREDERIC M. DUKES, Dugger. Member, Committee on Diabetes, 1953.

IRA L. FAITH, Evansville. Secretary, Warrick County Medical Society, 1949.

FRANK FORRY, Spartanburg, South Carolina, (formerly Indianapolis). Chairman, Instructional Courses, 1954; member, Committee on Necrology, 1954.

C. PHILIP FOX, Washington. Secretary, Daviess-Martin County Medical Society, 1935-37, 1940-45, 1949, 1953-67; delegate, Daviess County, 1944, 1954-56, 1958, 1960-61, 1963; member, Permanent Study Committee on Health Insurance, 1944; Committee on Credentials, 1945; Committee on Prepayment of Medical and Surgical Care, 1945; Committee on Scientific Exhibit, 1950; Committee on Alcoholics Study, 1950-53; Committee on Constitution and Bylaws, 1956-57; Commission on Special Activities, 1959-61, 1963; Commission on Aging, 1962-64, 1967.

ORVILLE G. HAMILTON, Bluffton. Delegate, Wells County, 1935-36; member, Committee on Rural Medical Care, 1944; Committee on Indigent Medical Care, 1948.

ROBERT M. HANSELL, Indianapolis.

Secretary, Marion County Medical Society, 1952; member, 1953 and 1956, and chairman, 1954, Committee on Convention Arrangements; vice-chairman, 1958, and member, 1959-62, Commission on Constitution and Bylaws.

DEWARD J. HOLLAND, Bloomington. Secretary, Monroe County Medical Society, 1922.

HERBERT H. INLOW, Shelbyville. Secretary, Shelby County Medical Society, 1933.

NICHOLAS A. JAMES, Tell City. Secretary, Perry County Medical Society, 1920, 1932, 1958; delegate, Perry County, 1943-47, 1949-50, 1956.

JOHN M. KERCHEVAL, Clinton. Secretary, Parke-Vermillion County Medical Society, 1960; delegate, Vermillion County, 1964-65.

COEN L. LUCKETT, Terre Haute. Delegate, Vigo County, 1934; member, Committee on Industrial Health, 1953, 1955; Commission on Inter-Professional Relations, 1958.

FRANK J. McMICHAEL, Gary. Delegate, Lake County, 1935, 1940-43; member, Committee on Civic and Industrial Relations, 1937-38.

GEORGE B. McNABB, Carthage. President, Rush County Medical Society, 1957.

ELWOOD J. MEREDITH, Richmond. Chairman, Section on Obstetrics and Gynecology, 1957-58.

MILO K. MILLER, South Bend. Member, State Board of Health Liaison Committee to Deal with Social Security Act, 1939; Advisory Committee to Bureau of Maternal and Child Health of Indiana State Board of Health, 1945-47.

LOUIS H. OSTERMAN, Seymour. Delegate, Jackson County, 1944; member, Committee on Traffic Safety, 1950.

CHARLES F. OVERPECK, Greensburg. Secretary, Decatur County Medical Society, 1928-30, 1935-37, 1942, 1963; member, Committee on Prevention of Traffic Accidents, 1937-38; Committee on Public Relations, 1940; Committee on Secretaries' Conference, 1940; councilor, Fourth District, 1945-Dec. 31, 1947, and 1951-53; delegate, Decatur County, 1948; president, Decatur County Medical Society, 1955 and 1964.

JOHN R. PORTER, Lebanon. Secretary, Boone County Medical Society, 1924, 1943-45, 1949-50, 1954; member, Committee on Prevention of Traffic Accidents, 1937-38; delegate, Boone County, 1949-50.

BERNARD D. RAVDIN, Evansville. Secretary, Vanderburgh County Medical Society, 1919; secretary, 1925-30, 1943, and chairman, 1930, Section on Ophthalmology and Otolaryngology; member, Committee on Hard of Hearing, 1943-47.

HERBERT M. RHORER, Sarasota, Florida (formerly Kokomo). Chairman, Committee on Scientific Work, 1928; delegate, Howard County, 1936.

CHARLES L. RICHARDSON, Rochester. Delegate, Fulton County, 1930, 1950; secretary, Fulton County Medical Society, 1935-36, 1959; member, Committee on School Health and Physical Education, 1953; president, Fulton County Medical Society, 1961.

PERRIE Q. ROW, Hammond. Delegate, Lake County, 1939-46, 1958-59; president, Lake County Medical Society, 1959.

HOMER B. SHOUP, Greentown (formerly Tipton). Secretary, Tipton County Medical Society, 1935; delegate, Tipton County, 1937.

JOHN P. SHOWALTER, Waterloo. Secretary, DeKalb County Medical Society, 1935-38; delegate, DeKalb County, 1944.

ROBERT STAFF, Terre Haute. Member, Anti-Tuberculosis Committee, 1941-42; Committee on Tuberculosis, 1950-53.

WILLIAM E. SYMON, Bluffton. Secretary, Wells County Medical Society, 1966.

JACK J. TURNER, Bloomfield. Secretary, 1954, and president, 1955, Greene County Medical Society.

HORACE WANNINGER, Richmond. Secretary, Wayne-Union County Medical Society, 1931-32.

JOHN H. WARVEL, Sr., Indianapolis. Secretary, 1939, vice-chairman, 1940, and chairman, 1941, Section on Medicine; delegate, Marion County, 1942; chairman, 1952, 1955-56, and member, 1954, Committee on Diabetes.

JOHN B. WESTFALL, Indianapolis. Member, Committee on School Health and Physical Education, 1952.

JAMES V. WHITE, Terre Haute. Delegate, Vigo County Medical Society, 1958-59.

Seymour Shapiro, Gary (Lake)
Truman E. Caylor, Bluffton (Wells)

REFERENCE COMMITTEE NO. 2:

Jack W. Hickman, Indianapolis (Marion), *Chairman*
John D. Wilson, Evansville (Vanderburgh)
John S. Farquhar, Fort Wayne (Allen)
Kenneth O. Neumann, Lafayette (Tippecanoe)
Frank McGue, Michigan City (LaPorte)

REFERENCE COMMITTEE NO. 3:

Peter R. Petrich, Attica (Fountain-Warren), *Chairman*
Robert M. Brown, Marion (Grant)
Vincent J. Santare, Munster (Lake)
Daniel M. Hare, Evansville (Vanderburgh)
Don E. Wood, Indianapolis (Marion)

REFERENCE COMMITTEE NO. 4:

Dean B. Jackson, Hartford City (Delaware-Blackford), *Chairman*
M. C. Topping, Terre Haute (Vigo)
Wayne H. Endicott, Greenfield (Hancock)
Robert G. Reed, Plymouth (Marshall)
Marshall H. Buchman, New Albany (Floyd)

Amendments to the Constitution

On motion of Dr. V. J. Santare, seconded by Dr. C. T. Disney, put to vote and carried, the House adopted the following amendments to the Constitution.

(Words or sections added are italicized).

1. **Article IV**, Sec. 2, amended by inserting after the word "the" in the last line the following words, "*district medical society and in,*" making this section read:

Sec. 2—Active Members.—The active members of this association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the *district medical society and in* the Indiana State Medical Association.

2. **Article VII** amended by inserting after the words, "such Societies to be composed exclusively of" and before the word, "members" the word "*all*" which would make the article read as follows:

Article VII—Sections and District Societies.—The House of Delegates may provide for a division of the scientific work of the association into appropriate sections and for the

1966 Minutes

On motion duly made, seconded by several, minutes of the meetings held at French Lick on October 10 and 13, 1966, were approved as printed in the December, 1966, Journal.

Introduction of Guests

HENRY B. ASMAN, M.D., Louisville, president-elect, Kentucky Medical Association.

H. J. KIEF, M.D., Fond du Lac, president, State Medical Society of Wisconsin.

J. P. SANFORD, Louisville, executive secretary, Kentucky Medical Association.

1967 Reference Committees

The chairman announced the appointment of reference committees for the 1967 session as follows:

REFERENCE COMMITTEE NO. 1:

T. Neal Petry, Delphi (Carroll),
Chairman
James A. Harshman, Kokomo (Howard)
Joseph L. Haymond, Indianapolis (Marion)

organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of all members of component county societies. Councilor districts shall be defined by the House of Delegates.

New Business

1. *Reference Committee Reports.* **Dr. Lowell H. Steen's motion to suspend the rules and to change the policy adopted by the House in 1963 of requiring reference committee reports to be available to delegates 24 hours in advance of the final meeting of the House, and to make the reports available at 4:00 p.m. on Wednesday, October 11, was seconded, put to vote, and carried.**

2. *Resolutions received by Committee on Rules and Order of Business.* Dr. T. Neal Petry, chairman, reported that the Committee on Rules and Order of Business had received two resolutions: (1) Concerning the Establishment of a Medical Department within the State Board of Correction, and (2) on Legislation concerning Abortions. **Dr. Petry's motion that the House consider both of these resolutions was duly seconded, put to vote, and carried.**

Reports of Reference Committees

REFERENCE COMMITTEE NO. 1

The following matters were referred to Reference Committee No. 1. All reports will be found on the pages indicated in the September, 1967, Vol. 60, *Journal of the Indiana State Medical Association* with the exception of the supplemental report of the Commission on Inter-Professional Relations, which is printed herewith. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Voluntary Health Agencies (pages 1242-44)

Commission on Public Health (pages 1241-42)

Commission on Inter-Professional Relations (pages 1244-45) and supplemental report

Commission on Aging (page 1249)

Grievance Committee (pages 1237-38)

Resolution No. 67-2—CREATION OF SECTION ON DIRECTORS OF MEDICAL EDUCATION

Resolution No. 67-15—AMA CONFERENCE ON COMPREHENSIVE

HEALTH PLAN

Resolution No. 67-20—M. D. ON DRIVER'S LICENSE

Resolution No. 67-23—FOREIGN RESIDENTS, INTERNS AND PHYSICIANS

Resolution No. 67-26—NARCOTIC STORAGE

Resolution No. 67-27—TUBERCULOSIS INSTITUTIONS

Resolution No. 67-29—POLICY ON ALLIED HEALTH ORGANIZATIONS

Resolution No. 67-32—LEGISLATION CONCERNING ABORTIONS

REFERENCE COMMITTEE ACTION

Dr. T. Neal Petry, chairman, presented the following report:

After completing its duties as the Committee on Rules and Order of Business and as the Credentials Committee, Reference Committee No. 1 met at 7:00 p.m. on October 9, 1967.

Voluntary Health Agencies

The first order of business was consideration of the report of the Commission on Voluntary Health Agencies. This committee wishes to commend this commission for its continued good work. In particular we would call attention to the admonition that the physicians of this state continue to "give sound medical guidance to these agencies which are working in the health field." We would also praise the commission for taking national leadership in developing the placard which names the Voluntary Health Agencies with statewide programs that have met the criteria established by this commission. The joint effort of this commission with the Indiana Public Health Association should continue.

During the discussion it was further noted that certain members of this commission failed to attend any of its meetings and that one district was not represented at all. It is not our intent to single out this commission but rather to point out a problem common to all the committees and commissions. We would strongly urge members of this society accept appointment only if they intend to fulfill their responsibilities.

Mr. Chairman, the committee approved this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Public Health

This committee next considered the report of the Commission on Public Health. This committee concurs with the commission and the Council that the original

function of Junior-Senior Day is now being carried out by the monthly G.P. Club efforts and therefore the emphasis for this one-day program should be shifted to encouraging all students to remain in our state to practice. Also plans were discussed for an effective statewide Health Fair. The physician must also concern himself with the development and maintenance of recreation facilities. Those facilities involved with water resources need urgent attention if these areas are to escape deaths from poor sanitation.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Supplemental Report of Commission on Inter-Professional Relations

The commission, at its September 17th, 1967 meeting, resolved to approve in principle a proposed law which would revise the Nursing Practice Act to incorporate mandatory licensure of nursing personnel. They did this, however, with the stipulation that final approval be withheld until the Act, in its final form, is resubmitted to the commission by the Indiana State Nurses Association.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, continued with the report of Reference Committee No. 1:

Inter-Professional Relations

The report of the Commission on Inter-Professional Relations was next. This committee concurs with the commission in withholding approval of proposed laws which would revise the Nursing Practicing Act to incorporate mandatory licensing of nursing personnel. This committee feels strongly that the commission should and will review this problem with the Indiana State Nurses Association before it is referred to other interested commissions such as the Legislative Commission.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Aging

This committee studied the report of the Commission on Aging and we move the adoption of this report as written.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Grievance Committee

The Grievance Committee report was well received. We would like to emphasize two portions of this report. First, that local medical societies should educate the public to those emergency arrangements available and thereby close the communication gap which so often leads to grievance problems.

Secondly, we concur that the publication entitled, "*Purposes, Rules, and Procedure of the Board of Appeals on Patient-Physician Relations*," (the Grievance Committee) be brought up to date and distributed to all members of the Indiana State Medical Association, present and future.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and adopted.)

Resolution No. 67-2

Introduced by: LAKE COUNTY MEDICAL SOCIETY
Subject: CREATION OF SECTION ON DIRECTORS OF MEDICAL EDUCATION

WHEREAS, there are now a number of fulltime medical directors in the state of Indiana, and,

WHEREAS, these physicians have organized as the Directors of Medical Education of Indiana and have actively met for several years, and,

WHEREAS, their goal is to promote all phases of medical education in the state of Indiana, including training of physicians, clerkships, externships, internships and residency training programs, as well as continuing medical education, and,

WHEREAS, Indiana University is in the process of establishing training centers at various sites throughout the state of Indiana as a regular part of the curriculum,

NOW, THEREFORE, BE IT RESOLVED that the House of Delegates of the Indiana State Medical Association establish a Section for Directors of Medical Education as a separate entity, separate and distinct from the other clinical sections now authorized by the Constitution and Bylaws, and in accordance with Chapter III, Section 1, Sub-Section L of the Constitution and Bylaws.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

The committee studied eight resolutions. The first was No. 2—CREATION OF SECTION ON DIRECTORS OF MEDICAL EDUCATION. We recommend its adoption as written and, Mr. Chairman, I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-15

Introduced by: THE COUNCIL
Subject: AMA CONFERENCE ON COMPREHENSIVE HEALTH PLAN

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association recommend the introduction and passage of a resolution at the next meeting of the American Medical Association requesting a conference of state associations in cooperation with the American Medical Association relative to Public Law 89-749 and the formulation of state plans pursuant to said law.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

Next we studied No. 15—AMA CONFERENCE ON COMPREHENSIVE HEALTH PLAN. We strongly urge its adoption as written and, Mr. Chairman, I do so move.

(Motion seconded, put to vote, and adopted.)

Resolution No. 67-20

Introduced by: THE COUNCIL
Subject: M.D. ON DRIVER'S LICENSE

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association ask that the president of the association appoint a committee to counsel with state officials and take whatever action is necessary to provide for the letters "M.D." to be inserted immediately following the name of a medical doctor on a driver's license from the state of Indiana.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

Next, No. 20—M. D. ON DRIVER'S LICENSE. The committee recommends the resolution be amended by adding the final words "*if the doctor so desires.*"

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-23

Introduced by: THE COUNCIL
Subject: FOREIGN RESIDENTS, INTERNS AND PHYSICIANS

WHEREAS, in 1966 one out of every six licensed physicians in the United States of America were graduates of foreign medical schools, and,

WHEREAS, in 1966 one out of every four residents and interns in the United States of America were graduates of foreign medical schools, and,

WHEREAS, many foreign medical schools mass-produce their graduates, and,

WHEREAS, a language barrier exists between said foreigners and the American patients, and,

WHEREAS, said residents, interns and physicians are needed in their own countries and have no understanding of the American way of life and are from socialistic countries which tends to make them favor socialized medicine,

NOW, THEREFORE, BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends to the House of Delegates of the Indiana State Medical Association that it request and seek passage of a resolution that the American Medical Association investigate the foreign resident, intern and physician program, appoint a committee to conduct such investigation and report to the next session of the House of Delegates.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

Resolution No. 23—FOREIGN RESIDENTS, INTERNS AND PHYSICIANS. After long and arduous discussion this committee wishes to amend the resolution to read as follows:

WHEREAS, in 1966 one out of six licensed physicians in the U.S. were graduates of foreign medical schools, and,

WHEREAS, in 1966 one out of four residents and interns in the U.S. were graduates of foreign medical schools, and,

WHEREAS, it is becoming more difficult for local and state medical societies to accurately assess the competence of graduates of diverse medical schools throughout the world, and,

WHEREAS, most countries are sorely in need of retaining their own medical graduates after a period of training in this country,

NOW, THEREFORE, BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends to the House of Delegates of the Indiana State Medical Association that it request and seek passage of a resolution that the American Medical Association investigate the foreign resident, intern and physician program, appoint a committee to conduct such investigation and report to the next session of the House of Delegates of the AMA.

Mr. Chairman, I move the adoption of this portion of the report.

(Dr. Petry's motion was duly seconded.)

Discussed by Dr. Farid who moved "to amend the committee's motion for adoption of the resolution by striking the resolution and putting in its place a committee of the House to investigate the shortcomings of licensure concerning foreign graduates."

Motion seconded. Discussed by Drs. Hickman, McGue, Shields, Green, Kerr, McIntosh, Lamey, Scharbrough, and Goodman. **(On a hand vote the motion for adoption of the amendment was lost, 56 to 47.)**

(Dr. Petry's motion for adoption of this section of the reference committee's report was put to vote, and carried.)

Resolution No. 67-26

Introduced by: LAKE COUNTY
MEDICAL SOCIETY
Subject: NARCOTIC
STORAGE

WHEREAS, it has been deemed proper by Federal Civil Defense officials to widely disperse all supplies including food, clothing, medicine, and emergency hospitals, as well as military material, in outlying areas not likely to be involved in major disasters of either military or civil nature, and,

WHEREAS, this principle has not been adopted in respect to narcotics, and these are currently stored in vaults only in our major cities,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association request the Narcotics Division of the United States Treasury Department to undertake the immediate dispersal of narcotic storage to equally secure, but more widely dispersed centers, safely distant from the most likely disaster sites.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

Next we studied Resolution No. 26—NARCOTIC STORAGE and we recommend

its adoption as written. Mr. Chairman, I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-27

Introduced by: LAKE COUNTY
MEDICAL SOCIETY
Subject: TUBERCULOSIS
INSTITUTIONS

WHEREAS, treatment of tuberculosis is, and should be, carried out today increasingly on an outpatient basis, and,

WHEREAS, there has been a rapidly decreasing patient load at tuberculosis institutions which are maintained at the taxpayers' expense, and,

WHEREAS, it would be more practical to combine several of such institutions into fewer in number, and thus provide better staffing and better care at less expense, and,

WHEREAS, such institutions could then be supplemented by less expensive and more readily accessible outpatient clinics for follow-up care,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association seek whatever changes are required in the state laws and public health regulations to bring about the designation of three or four existing tuberculosis hospitals as regional hospitals, thus freeing other institutions for other uses in their communities or areas.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

The committee also considered Resolution No. 27—TUBERCULOSIS INSTITUTIONS and recommended its adoption as written. Mr. Chairman, I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-29

Introduced by: THE COUNCIL
Subject: POLICY ON ALLIED
HEALTH ORGANIZATIONS

BE IT RESOLVED, that the Council of the Indiana State Medical Association recommends to the House of Delegates that it adopt a policy of discouraging allied health agencies from infringing on the clinical practice of medicine and that the House refer this matter, after adoption, to the Commission on Inter-Professional Relations for implementation.

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the fol-

lowing report:

After studying Resolution No. 29—POLICY ON ALLIED HEALTH ORGANIZATIONS, we recommend its adoption as written. Mr. Chairman, I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-32

Introduced by: MORGAN COUNTY
MEDICAL SOCIETY
Subject: LEGISLATION
CONCERNING
ABORTIONS

WHEREAS, the laws of the state of Indiana concerning illegal abortions have remained unchanged since 1905, and,

WHEREAS, there have been outstanding advances in medical knowledge and public thinking since that time, and,

WHEREAS, the last General Assembly of the state of Indiana attempted to bring these laws up to date, and,

WHEREAS, several other states have changed or are in the process of changing outmoded and archaic laws concerning abortion, and,

WHEREAS, it is incumbent upon the Indiana State Medical Association to provide leadership and assistance in this field,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association recommends to the Commission on Legislation that it cause to be introduced and seek passage of the attached bill which would amend Sections 367 and 368 of Chapter 169 of the Acts of 1905, the effect of such legislation being that in certain cases abortions would be permitted and properly regulated.

A BILL FOR AN ACT to amend Sections 367 and 368 of an Act entitled "An act concerning public offenses" approved March 10, 1905, the same being Chapter 169 of the Acts of 1905, concerning illegal abortions, and the solicitation thereof, providing penalties therefor, creating exceptions thereto, and to add a new section establishing requirements for the performance of abortions permitted under this Act.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF INDIANA:

SECTION 1. Acts 1905, c.169, s.367 is amended to read as follows: Sec. 367. Attempt to procure miscarriage. — Whoever prescribes or administers to any pregnant woman, or to any woman whom he supposes to be pregnant, any drug, medicine or substance whatever, with intent thereby to procure the miscarriage of such a woman, or with like intent uses or suggests, directs or advises the use of any instrument or means whatever, shall, on conviction, if the

woman miscarries, or dies in consequence thereof, be fined not less than one hundred dollars (\$100.00) nor more than one thousand dollars (1,000.00), and be imprisoned in the state prison not less than three (3) years nor more than fourteen (14) years; Provided, however, it shall not be a violation of this Act where a duly licensed physician in good faith terminates or attempts to terminate a pregnancy, (1) in the belief that the termination of the pregnancy is necessary to avoid serious danger to the life or health of the pregnant woman; or (2) in the belief that there is a substantial risk that the child may be born with grave physical or mental defect; or (3) in the belief that the woman became pregnant as the result of intercourse which was an offense under Acts 1941, c.148, s.3 (Rape and Statutory Rape) and which was reported to the proper authorities within a reasonable time after commission of the intercourse or Acts 1905, c.169, s.456 as amended by Acts 1907, c.74, s.1 (Incest) and which was reported to the proper authorities.

SEC. 2. Acts 1905, c.169, s.367 is further amended to add a new section to read as follows: Sec. 367A. In the case of any abortion performed in conformity with Section 367, (1), (2), (3) it shall be required that such abortions be performed in duly accredited hospitals and that three (3) duly licensed physicians, all of whom must be members of the staff of that hospital, one of whom may be the physician performing the abortion, and none of whom may be associated with the others in the practice of medicine, certify in writing their belief in the existence of one or more of the justifying circumstances as set forth in Section 367 of this Act, and make this a part of the hospital record prior to performance of such abortion. Each hospital shall report annually the number of abortions performed therein and the reasons for performing such abortions to the Indiana State Board of Health. Physicians terminating pregnancy under this act shall be empowered to do so only when the pregnant woman is a resident of the State of Indiana and was a resident of the State of Indiana at the time of conception.

SEC. 3. Acts 1905, c.169, s.368 is amended to read as follows: Sec. 368. Woman soliciting medicine for miscarriage.—Every woman who shall solicit of any person any medicine, drug, or substance or thing whatever, and shall take the same, or shall submit to any operation or other means whatever, with intent thereby to procure a miscarriage, except when done by a physician as permitted by Sections 367 and 367A of this Act, shall, on conviction, be fined not less than ten dollars

(\$10.00) nor more than five hundred dollars (\$500.00), and be imprisoned in the county jail not less than thirty (30) days nor more than one (1) year; and any person who, in any manner whatever, unlawfully aids or assists any such woman in violation of this section shall be liable to the same penalty.

(Amends Burns §§ 10-105 and 10-106)
DULY PASSED BY THE INDIANA
JAYCEE MODEL LEGISLATURE,
SEPTEMBER 24, 1967

REFERENCE COMMITTEE ACTION

Dr. Petry, chairman, presented the following report:

Resolution 67-32—LEGISLATION CONCERNING ABORTION was considered and after much discussion about the multiple ramifications of this subject, it was the unanimous recommendation that this resolution and its accompanying proposed act be referred to the Commission on Legislation for study. Mr. Chairman, I do so move.

(Motion seconded.)

Discussed by Drs. Schuster, Petry, Senseny, Black and Steen. **Dr. Reese offered a substitute motion for the motion of the committee, the substitute motion being "to pass the resolution as originally presented." (Motion lost for want of a second.)**

Dr. Steen moved to amend the report of the reference committee to include the following phrase, "and to work for the passage of an updated bill relative to this subject." (Motion seconded.)

Dr. Gosman moved to amend the amendment to the reference committee report by adding after the word "study" the words "as to whether it is in accord with the present policy of the AMA and if so, implement it. (Motion seconded, put to vote, and carried.)

Dr. Steen's motion for amendment of the reference committee report was put to vote, and carried.

(Dr. Petry's motion for adoption of this section of the report, as amended, was seconded, put to vote, and carried.)

I wish to thank Drs. Harshman, Haymond, Shapiro and Caylor for wise counsel and penetrating insight which combined to make this report possible.

Mr. Chairman, I move the adoption of this report as amended as a whole.

(Motion seconded, put to vote, and carried.)

Dr. Rifner asked for the privilege of the House to thank Dr. Farid for his

presentation and discussion of Resolution No. 23 concerning foreign residents, interns and physicians.

REFERENCE COMMITTEE NO. 2

The following matters were referred to Reference Committee No. 2. All reports will be found on the pages indicated in the September, 1967, Vol. 60, *Journal of the Indiana State Medical Association* with the exception of the Maternal Mortality Study report, copy of which was handed to each delegate, and the report of the State Board of Medical Registration and Examination, which is printed below. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (page 1245)

Commission on Special Activities (pages 1245-49)

Commission on Governmental Medical Services (no written report)

Student Loan Committee (page 1238)

Commission on Convention Arrangements (no printed report)

Maternal Mortality Study report (copy handed to each delegate)

State Board of Medical Registration and Examination report

Resolution No. 67-1—MEMBERSHIP OF DISABLED PHYSICIANS

Resolution No. 67-3—TRAINING FAMILY PHYSICIANS

Resolution No. 67-7—CONTRACTUAL ARRANGEMENTS BETWEEN PHYSICIANS AND HOSPITALS

Resolution No. 67-10—MANNER OF PAYMENT TO PHYSICIANS FOR WELFARE CASES

Resolution No. 67-13—DEFINITION OF "USUAL" AND "CUSTOMARY", "REASONABLE" AND "PREVAILING" FEE

Resolution No. 67-14—AMA TO ANSWER CRITICISM OF MEDICINE

Resolution No. 67-31—ESTABLISHMENT OF MEDICAL DEPARTMENT WITHIN STATE BOARD OF CORRECTION

REFERENCE COMMITTEE ACTION

Dr. Jack W. Hickman, chairman, presented the following report:

Mr. President, your Reference Committee No. 2 is pleased to present its recommendations to you and this House on the following business which was referred to our committee.

At the outset we would like to thank all those members who appeared before our committee to voice their opinions on the

business referred to this committee. These opinions were most helpful to us in formulating our recommendations.

Medical Education

Your committee recommends that the report of the Commission on Medical Education and Licensure be adopted and that the commission be commended for its work. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Special Activities

Our committee wishes to commend the Commission on Special Activities for its work and for the admirable quality of its work in drawing up an educational program for new members. We did note that the list of blood banks as it appeared in the Handbook is incomplete and we would encourage the commission to continue its work to complete this list. Our committee noted expressions of displeasure with federal control of blood banks and we would hope that the commission would be able to continue work to correct this situation.

Mr. Chairman, your committee recommends that the House of Delegates adopt this report and that the Commission on Special Activities be commended for its work. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Governmental Medical Services

This committee was assigned the chore of reviewing the report of the Commission on Governmental Medical Services. We were informed that no written report was available from this commission and furthermore that no chairman of this commission had been assigned. Mr. President, your reference committee feels that this is indeed a vitally important area for our association and we recommend prompt activation of this commission, with reports to be sent to the membership as soon as possible. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Student Loan

This reference committee reviewed the report of the Student Loan Committee and recommends that this report be adopted and that the committee be commended for its work. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Convention Arrangements

Our reference committee reviewed the activities of the Commission on Convention Arrangements as manifested by the scientific program and scientific exhibits at this meeting and we are pleased to acknowledge the excellent work of this commission and to commend it for its efforts. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Maternal Mortality Study

Our committee reviewed the report of the Maternal Mortality Study Committee and recommends that this report be adopted by the House of Delegates and that the committee be commended. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Report of Board of Medical Registration and Examination of Indiana, July 1, 1966 to June 30, 1967

Number of medical candidates who took the state board examination	376
Number of medical candidates who failed the state board examination	52
Number of medical candidates who failed in one subject only	17
Number of medical candidates from Indiana University Medical School who took state board examination	179
Number of medical candidates from foreign and American medical schools who took state board examination	197
Number of medical candidates from Indiana University Medical School who failed the state board examination	0
Number of medical candidates from foreign and American medical schools who failed the state board examination	52
Number of candidates who took chiropractic state board examination	0
Number of candidates who took the physical therapy state board examination	3
Number of candidates who failed the physical therapy examination	0
Number of candidates who took the podiatrist state board examination	3
Number of candidates who failed podiatry examination	0
Number of candidates who took midwifery state board examination	1
Number of candidates who failed midwifery examination	0
Number of medical applicants granted license in Indiana by endorsement/reciprocity	170

Number of medical applicants who were endorsed to other states	224
Number of osteopathic applicants granted license in Indiana by endorsement/reciprocity	14
Number of osteopaths who endorsed to other states	0
Number of applicants granted physical therapy license in Indiana by endorsement/reciprocity	26
Number of physical therapists endorsed to other states	1
Number of applicants granted chiropractic license in Indiana by endorsement/reciprocity	26
Number of chiropractors endorsing into other states	1
Number of citations during the year (all M.D., D.C., D.O.)	9
Number of revocations during the year (all M.D., D.C., D.O.)	0
Number of physicians who voluntarily surrendered their narcotic stamps to the Internal Revenue Dept., Post Office	3
Examination:	
417 applications received for the June 1967 state board examination:	
181 I.U. graduates (two not taking)	179
236 foreign and American graduates (38 not taking)	197
3 physical therapy examination applications	3
3 podiatrist taking examination	3
1 midwifery taking examination	1
	383
33 foreign graduates ineligible	
450 total applications.	
40 eligible for examination but failed to appear	
383 applicants taking the June, 1967, state board examination.	
Medical Licensure	1966 1967
MD's resident	
MD's non-resident Total	6915 7012
DO's (medical resident and non-resident)	240 254
DO's (regular resident and non-resident)	26 20
Drugless (resident and non-resident)	234 212
Chiropractic (resident and non-resident)	346 342
Physical therapist—resident	245 269
Podiatrist	213 201
Temporary physical therapist permits issued from July 1, 1966 to June 30, 1967	1 3
Temporary internship permits issued from July 1, 1966 to June 30, 1967	19 78
Temporary teaching permits issued from July 1, 1966 to June 30, 1967	1 2

New medical doctors that have entered the state by reciprocity from July 1, 1966 to June 30, 1967 106 170

Number of medical D.O.'s that have entered the state by reciprocity from July 1, 1966 to June 30, 1967 5 14

Medical Board of Registration and Examination of Indiana

R. A. Snapp, M.D., Secretary

Joseph D. O'Brien, Administrator

STATISTICAL REPORT

July 1, 1966 to June 30, 1967

Physicians licensed by examination (all branches of healing)	314
Physicians licensed by endorsement/license	170
Physicians endorsed to other states for license	224
Physicians to repeat examination in one subject	17
Revenue:	
Fees for licensure and endorsement	\$21,056.00
Fees for examination	9,675.00
Duplicate certificates issued	30.00
Temporary medical permits	238.00
Temporary medical educational permit	850.00
Medical corporation act fee	200.00
Annual registration fees	100,000.00
	<u>\$132,049.00</u>
Less refund of examination fees	100.00
Total revenue	<u>\$131,949.00</u>

Disbursements:	
Personal service	\$43,354.71
Other operating equipment	9,346.68
Total disbursements	<u>\$52,701.42</u>
Reverted to General Fund	\$79,247.58

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Our committee reviewed the report of the State Board of Medical Registration and Examination. Mr. Chairman, it was once again drawn to our attention that over \$79,000.00 received by this board was turned back to the General Fund of the State of Indiana and was therefore, not available to the board for its activities. We wish to lend the support of our committee to the future actions of this board to see that it has access to this money for its activities. We do indeed commend this board for its work. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Regarding the resolutions referred to this reference committee, we wish to report as follows:

Resolution No. 67-1

Introduced by: CLAY COUNTY MEDICAL SOCIETY

Subject: MEMBERSHIP OF DISABLED PHYSICIANS

WHEREAS, there is no provision in the Constitution and Bylaws of the Indiana State Medical Association for continuing membership of those physicians, who by their own admission are deemed to be permanently disabled, except for remission of their dues, and,

WHEREAS, such remission of dues has many of the aspects of charity, and,

WHEREAS, such procedure has a demoralizing effect on the disabled physicians and approaches professional abandonment of such physicians by his colleagues and his association,

NOW, THEREFORE, BE IT RESOLVED, that an additional classification of membership be added to those already in force and that such physicians receive membership cards and *The Journal of the ISMA* the same as regular members and without charge. Proof of such disability shall be by notification of the secretary of the association by the secretary of the county society in which the physician has held membership.

CHAPTER XXVII Sec. 12 Paragraph 4

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 1—MEMBERSHIP OF DISABLED PHYSICIANS. We recommend that this resolution be amended by inserting after the word “disabled” in the third line the words “and no longer able to practice.”

The committee approves the resolution as amended and recommends its adoption. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

The committee recommends that this resolution be referred to the Commission on Constitution and Bylaws for consideration and implementation. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-3

Introduced by: HENDRICKS COUNTY MEDICAL SOCIETY

Subject: TRAINING FAMILY PHYSICIANS

WHEREAS, the need for training family physicians has been established by the Ad Hoc and Millis Committees of the American Medical Association, and,

WHEREAS, the general public desires and is entitled to care by a properly trained family physician, and,

WHEREAS, the medical student does not have contact with practicing family physicians during his academic years except through the G.P. Club, and,

WHEREAS, the G.P. Club has cooperated with and is complementary to the Indiana State Medical Association Preceptorship Program, and,

WHEREAS, the G.P. Club has held regular meetings with medical students, and their wives, attempting to interest them in family practice and to provide an educational opportunity unavailable elsewhere, and,

WHEREAS, the G.P. Club has implemented an “Office Visitation Program” to family physicians’ offices for all medical students,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Indiana State Medical Association approve and support the purpose and efforts of the General Practice Club of Indiana and urge this program and its purposes be expanded to a state and national scope.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 3—TRAINING FAMILY PHYSICIANS. Your committee recommends that Resolution No. 3 be amended in the third WHEREAS by deleting the words “does not have” and substituting the words “has very little.” We further recommend that in the fourth WHEREAS, following the words “Indiana State Medical Association” the words “and Indiana University School of Medicine” be inserted.

The committee approves the resolution as amended and recommends its adoption. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-7

Introduced by: MARION COUNTY
MEDICAL SOCIETY

Subject: CONTRACTUAL AR-
RANGEMENTS BE-
TWEEN PHYSICIANS
AND HOSPITALS

WHEREAS, the Council of the Indiana State Medical Association in the spring of 1966 did formulate an official policy of the ISMA declaring participation by a physician in any financial arrangement with a hospital other than on the basis of direct billing of the patient by the physician as an unethical act, and,

WHEREAS, the majority of hospital based physicians in Indiana have not been able to obtain such an arrangement, and,

WHEREAS, emergency room service has recently been added to the areas in the hospital where a physician may enter into a contractual arrangement with a hospital, and,

WHEREAS, organized hospital medical staffs must be willing to assume the responsibility in the area of economics of medical care, as well as in the traditional areas of patient care, in order that the best interests of the patient and the profession be served, and,

WHEREAS, the House of Delegates of the American Medical Association in June, 1967, did reaffirm past actions and provide clear policy statements which can be used as guides in these matters through the adoption of a Report of the Council on Medical Service which includes the following:

"A physician should not enter into a contract or agreement with a hospital whereby the hospital acts as an agent for the physician unless it is with the consent of the physician and the medical staff. The physician and the medical staff as principals should not approve any contract whose terms or conditions are inconsistent with the principles of medical ethics and the established policy of the American Medical Association.", and,

WHEREAS, hospital medical staffs in Indiana should be informed through their county medical societies on the guidelines established by the AMA,

NOW, THEREFORE, BE IT RESOLVED, that it shall be unethical for a physician to enter into any contract or agreement with a hospital unless such contract has been reviewed and approved by the medical staff of the hospital.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 7—CONTRACTUAL ARRANGEMENTS BETWEEN PHYSICIANS AND HOSPITALS. Mr. President, your committee recommends that Resolution No. 7 be amended as follows:

That in the third WHEREAS the words "emergency room service has recently been" be deleted and the following words be inserted: "Services other than pathology and radiology are being", and that it further be amended by striking in its entirety the fourth WHEREAS, and that the resolution be further amended by changing the word "unethical" to "ethical" and by deleting the words "unless such" and inserting in lieu thereof the words "if and only if" and adding after the word "contract", the words "excluding salary" so that the resolution shall read:

"NOW, THEREFORE, BE IT RESOLVED, that it shall be ethical for a physician to enter into any contract or agreement with a hospital if and only if such contract, excluding salary, has been reviewed and approved by the medical staff of the hospital."

Mr. President, the committee approves the resolution as amended and recommends its adoption, and I so move.

By consent the House accepted an editorial change in the Resolve, deleting the words "excluding salary," and inserting in their place the words, "excluding the amount of remuneration."

(Dr. Shapiro's motion to amend the resolution by adding after the words, "medical staff of the hospital" the words "and the county medical society," was seconded, put to vote, and carried.)

Dr. Hickman continued with the report of Reference Committee No. 2:

Mr. President, the committee approves the resolution as amended and recommends its adoption, and I do so move.

(Motion seconded by Dr. Shapiro, put to vote, and carried.)

I move that the House accept this portion of the report as amended.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-10

Introduced by: HOWARD COUNTY
MEDICAL SOCIETY

Subject: MANNER OF PAY-
MENT TO PHYSI-
CIANS FOR WEL-
FARE CASES

WHEREAS, the present arrangement for payment of physicians for welfare cases allows Blue Shield to set fees for physician efforts, leaving the responsibility of objecting up to the physician, and,

WHEREAS, this is extremely odious to the practicing physician of ISMA and is contrary to the American way of life,

NOW, THEREFORE, BE IT RESOLVED, that the present arrangement be abandoned and that instead, a system be devised whereby the physician has the right to set his fee and the insurance company has the right to object; and further, that this objection be made to a committee of representatives of the insurance company and a board of censors of the local medical society; that committee consisting of an equal number of insurance representatives for the number of local board censors, and,

BE IT FURTHER RESOLVED, that the House of Delegates of the ISMA accept nothing less than this resolution in their agreement with Blue Shield, with any other official welfare carrier, or with the Indiana Welfare Department, itself, for physician payment in welfare cases, and,

BE IT FURTHER RESOLVED, that this resolution, when passed, be presented to the next AMA convention by the Indiana delegation.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 10—MANNER OF PAYMENT TO PHYSICIANS FOR WELFARE CASES. Mr. Chairman, your committee considered thoroughly Resolution No. 10. It was called to our attention very clearly in the committee hearings that the desired policies of the resolution are in effect to as full an extent as is possible under the provisions of the present law. For this reason, your committee disapproves this resolution and recommends its rejection. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded.)

Dr. Warren McClure moved to amend this portion of the reference committee's report by replacing it with the following paragraph:

"BE IT RESOLVED, that the present arrangement between Blue Shield, the State Department of Welfare and the Indiana State Medical Association that calls for a blanket assignment form to be signed by the physician is odious to this House of Delegates; and further,

"That this House of Delegates urges the president, the Executive Committee and the Council to do all in their power to

remove this abrogation of freedom from this or any other arrangements having to do with physician payment."

(Motion duly seconded; discussed by Drs. Steen, Hill, Neumann, Kerr and McClure; put to vote, and carried.)

Dr. Hickman continued with the report of Reference Committee No. 2:

I think that deleted this portion of our report, did it not, Mr. Chairman?

(The chairman announced that the amendment just adopted had deleted the reference committee's report on Resolution No. 10, and a call for a motion to adopt was not necessary for that which had been deleted.)

Resolution No. 67-13

Introduced by: THE COUNCIL
Subject: DEFINITION OF
"USUAL" AND
"CUSTOMARY",
"REASONABLE" AND
"PREVAILING" FEE

BE IT RESOLVED, that the Council of the Indiana State Medical Association submits the following definitions of "usual", "customary", "prevailing" and "reasonable" fee to the House of Delegates and recommends its approval by such body:

The term usual and customary fee shall mean and shall be defined and used as the usual and customary fee of the physician. The term prevailing fee shall mean and shall be defined and used as the prevailing fee of the physician.

The term reasonable fee shall mean and shall be defined and used as the reasonable fee of the physician. The use of any other term similar to or in place of usual and customary fee, prevailing fee, or reasonable fee shall mean and shall be defined as the fee of the physician.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 13—DEFINITION OF "USUAL" AND "CUSTOMARY" "REASONABLE" AND "PREVAILING" FEE. Your committee recommends that this resolution be referred to the Commission on Medical Economics and Insurance for further study and return to the House of Delegates at next year's meeting. Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-14

Introduced by: THE COUNCIL
Subject: AMA TO ANSWER
CRITICISM OF
MEDICINE

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association recommend the introduction and passage of a resolution at the next meeting of the AMA that the American Medical Association answer criticism of medicine within 48 hours following said criticism, cooperate with state and local societies and take whatever action is necessary to implement this request.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 14—AMA TO ANSWER CRITICISM OF MEDICINE. Mr. Chairman, your committee considered Resolution No. 14. We would recommend that this resolution be amended as follows: In line 5, the words "within 48 hours" be deleted and in their place the words "promptly and appropriately" be substituted. The committee approves the resolution as amended and recommends its adoption, and I so move. **(Motion for adoption of the amendment to Resolution No. 14, seconded, put to vote and carried.)**

Mr. Chairman, I move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-31

Introduced by: LAPORTE COUNTY
MEDICAL SOCIETY
Subject: ESTABLISHMENT
OF MEDICAL
DEPARTMENT
WITHIN STATE
BOARD OF
CORRECTION

WHEREAS, certain members of the LCMS, who are directly involved with the medical care of the inmates of Indiana State Prison, Michigan City, have been critical of working conditions in the prison hospital, and,

WHEREAS, the members of the LCMS feel that the major factor interfering with good medical care in the ISP, Michigan City, is the lack of a co-ordinated medical care program within the Department of Corrections, which program could organize the medical care for the corrections department with special reference to procurement of personnel, equipment, and supplies; and especially could effect long range planning, and savings thru more efficient utilization of funds and services for all the prisons and corrections institutions in the state,

NOW, THEREFORE, BE IT RESOLVED, the LCMS again urges the ISMA to recommend to the Governor of State of Indiana and the State Legislation Council that a medical department be established within the Department of Corrections, the purpose of which would be to organize and administer the medical care program for all the corrections institutions in the state.

REFERENCE COMMITTEE ACTION

Dr. Hickman, chairman, presented the following report:

Resolution No. 31—ESTABLISHMENT OF MEDICAL DEPARTMENT WITHIN THE STATE BOARD OF CORRECTION. Mr. Chairman, your committee studied Resolution No. 31 and is pleased to offer its recommendation. Your reference committee feels that the House of Delegates should reaffirm its position and that this resolution should be adopted, and I so move the adoption of this portion of the report.

(Motion seconded, put to vote, and carried.)

Mr. President, I move the adoption of this report as a whole.

(Motion seconded, put to vote, and carried.)

Finally, I would like to thank very much the members of Reference Committee No. 2—Dr. John D. Wilson, Dr. John S. Farquhar, Dr. Kenneth O. Neumann, and Dr. Frank McGue, whose guidance and patience have been most helpful to me in preparing this report.

REFERENCE COMMITTEE NO. 3

The following matters were referred to Reference Committee No. 3. All reports will be found on the pages indicated in the September, 1967, Vol. 60, *Journal of the Indiana State Medical Association* with the exception of the report of Glen V. Ryan, M.D., chairman of the Blue Shield Board of Directors, which was handed to each delegate, and Dr. Ryan's remarks before the House, which are printed below. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (pages 1240-41)

Commission on Public Information (no written report)

Commission on Medical Economics and Insurance (page 1244)

Report of Glen V. Ryan, M.D., chairman, Blue Shield Board of Directors (handed to each delegate)

Resolution No. 67-4—FORM FOR BILLING OF COUNTY, STATE, AMA AND IMPAC DUES

Resolution No. 67-5—SUPPORT OF IMPAC AND AMPAC

Resolution No. 67-6—COMPUTERIZED SYSTEM FOR BILLING FOR DUES

Resolution No. 67-8—SURVEY OF ISMA MEMBERSHIP REGARDING SERVICES OFFERED BY INDIANA STATE MEDICAL ASSOCIATION

Resolution No. 67-17—COMPUTER SYSTEM

Resolution No. 67-18—SURVEY OF MEMBERSHIP

Resolution No. 67-19—BILLING AND COLLECTING DUES

Resolution No. 67-21—SUPPORT OF IMPAC

Resolution No. 67-22—VOLUNTARY CONTRIBUTION TO IMPAC AND AMPAC

REFERENCE COMMITTEE ACTION

Dr. Peter R. Petrich, chairman, presented the following report:

The committee wishes to thank all of the members of the association, which numbered in excess of 50, who appeared before us to voice their opinions. Their presence and comments were greatly appreciated.

Resolution No. 67-4

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: FORM FOR BILLING OF COUNTY, STATE, AMA AND IMPAC DUES

WHEREAS, the House of Delegates of the American Medical Association in 1965 and again in 1966 urged state medical associations to recommend voluntary participation in IMPAC and AMPAC and that this participation be as universal as possible, and,

WHEREAS, the American Medical Association House of Delegates on the same two occasions urged the desirability of a common billing service to be provided by state medical associations whereby voluntary, non-deductible, contributions be made to political action committees,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates urge the Council of the association to prepare a common billing form which may be used for the billing of county, district, state, AMA and IMPAC dues and contributions, and,

BE IT FURTHER RESOLVED, that the use of this form be voluntary by each county medical society.

Resolution No. 67-6

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: COMPUTERIZED SYSTEM FOR BILLING FOR DUES

WHEREAS, the majority of our county medical societies have a practicing physician who acts as secretary of said society, and,

WHEREAS, the paperwork necessary for these men to carry on the collection of dues requires much of their valuable time, and,

WHEREAS, it is possible for the state association to provide a computerized system for billing all members for their dues, and,

WHEREAS, this would make it possible for the physician to write only one check instead of three or four checks, and,

WHEREAS, the state association could collect the dues from all members and return the appropriate amounts to the county society and the district societies with a computerized report and thereby relieve county society officers of this burdensome task,

NOW, THEREFORE, BE IT RESOLVED, that the state association establish a system of computerized billing for the collection of all dues and for distribution of these dues separately to the respective societies and that this service be done at no expense to the county societies, and,

BE IT FURTHER RESOLVED, that this service be offered to counties who wish to avail themselves of this service.

Resolution No. 67-17

Introduced by: THE COUNCIL
Subject: COMPUTER SYSTEM

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association authorize the Council to adopt a computer system of billing for the state association to be used for all county, state and AMA dues, and voluntary PAC contributions.

Resolution No. 67-19

Introduced by: THE COUNCIL
Subject: BILLING AND COLLECTING DUES

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends to the House of Delegates of the Indiana State Medical Association that it authorize the Council to prepare a method for billing and collecting dues whereby the state association can

assist all county and district societies in the performance of these duties.

REFERENCE COMMITTEE ACTION

Dr. Petrich, chairman, presented the following report:

Resolutions #4, 6, 17 and 19 were concerned with centralized billing and as such were taken as a group by the committee for purposes of discussion. The committee was pleased with the remarks of the president, president-elect, executive secretary, chairman of the Council, and the numerous delegates representing their component societies. In view of the similarity of these resolutions, the committee, on the basis of the consensus of remarks made in committee meeting, offers a single resolution as follows:

"WHEREAS, the American Medical Association House of Delegates on two occasions urged the desirability of a common billing service to be provided by state medical associations;

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates urge the Council of the association to prepare a common billing form which may be used for the billing of county, district, state and AMA dues, and,

BE IT FURTHER RESOLVED, that the use of this form be voluntary by each county medical society."

Mr. Chairman, this committee approves this resolution and recommends its adoption, and I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-5

Introduced by: MARION COUNTY MEDICAL SOCIETY
Subject: SUPPORT OF IMPAC AND AMPAC

WHEREAS, the American Medical Association and the Indiana State Medical Association have previously endorsed the establishment of independent, voluntary, non-profit and bipartisan organizations to promote political education and political action known as the American Medical Political Action Committee, AMPAC, and the Indiana Health Organization For Political Action now known as Indiana Medical Political Action Committee, IMPAC, and,

WHEREAS, in all 50 states and the District of Columbia independent non-profit, nonpartisan, voluntary and unincorporated political action committees have been formed, and,

WHEREAS, membership in AMPAC and IMPAC is open to physicians, their wives and friends, and,

WHEREAS, physician activity in 1966 culminated in an all-time high of individual political participation across the country with encouraging results, and,

WHEREAS, it is essential to continue preparation for 1968 by supporting IMPAC-AMPAC membership programs and by participation in political education projects,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates reaffirm its support of AMPAC and IMPAC, and,

BE IT FURTHER RESOLVED, that the members of this House of Delegates urge the leaders and membership of their local organizations to continue their support of IMPAC and AMPAC and to demonstrate their support by a membership contribution and participation in their local PAC program.

Resolution No. 67-21

Introduced by: THE COUNCIL
Subject: SUPPORT OF
IMPAC

WHEREAS, the Council of the Indiana State Medical Association has indicated its strong support of the American Medical Political Action Committee and the Indiana Medical Political Action Committee, independent committees, which working with like committees in other states, have been responsible for a major contribution to the nation's system of government and political action, and,

WHEREAS, the cause and effect relationship between the actions of medical political action committees and the election of responsible men to public office is hard to establish, but there is no doubt, however, that the funds raised by these committees have been of inestimable value to those whose campaigns have been supported and—perhaps even more important—the organizational assistance and wise counsel that have been available have served to strengthen existing campaign organizations and, in more than a few instances, to provide the catalytic agent for their creation, and,

WHEREAS, between now and November, 1968, our nation will be in the midst of a most intensive campaign by opposing forces to control the direction in which our nation will move; toward one in which decisions are made ever more frequently by centralized super-authority, implemented by coercive laws and regulations; or toward an opportunity society in which individual performance and a health competitive climate operate to provide an optimum degree of decision making by the private sector and at those levels of government closest to the people, and,

WHEREAS, the Council believes that

never before has the medical PAC movement more strongly deserved and needed your support and the support of all members of the profession and the county medical societies and there should be maximum voluntary participation in the national and state PACS as independent organizations established under the law by the entire profession and especially by its leadership,

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the ISMA urge every physician and his wife to actively participate in political action committee activities, and that we strongly urge the county medical societies to use their influence in stimulating voluntary participation and that this participation be as universal as possible.

REFERENCE COMMITTEE ACTION

Dr. Petrich, chairman, presented the following report:

The next resolutions to be considered were resolutions #5 and 21, relative to the support of IMPAC and AMPAC. The committee offers to the House of Delegates the following resolution:

"WHEREAS, the American Medical Association and the Indiana State Medical Association have previously endorsed the establishment of independent, voluntary, non-profit and bipartisan organizations to promote political education and political action known as the American Medical Political Action Committee, AMPAC, and the Indiana Health Organization for Political Action, now known as Indiana Medical Political Action Committee, IMPAC, and,

WHEREAS, in all 50 states and the District of Columbia independent, non-profit, nonpartisan, voluntary and unincorporated political action committees have been formed, and,

WHEREAS, membership in AMPAC and IMPAC is open to physicians, their wives and friends, and,

WHEREAS, physician activity in 1966 culminated in an all-time high of individual political participation across the country with encouraging results, and,

WHEREAS, it is essential to continue preparation for 1968 by supporting IMPAC-AMPAC membership programs and by participation in political education projects;

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the ISMA urge every physician and his wife to actively participate in PAC activities, and that we strongly urge the county medical societies to use their influence in stimulating voluntary participation of a universal nature, and,

BE IT FURTHER RESOLVED, that this House of Delegates reaffirm its support of AMPAC and IMPAC."

Mr. Chairman, the committee approves this resolution and recommends its adoption, and I do so move.

(Motion seconded, put to vote, and carried.)

Mr. Chairman, to continue and complete the thoughts and ideas of the multiple resolutions of similar nature and the provoking comments of those appearing and making known their views, the committee offers the following resolution:

"WHEREAS, the House of Delegates of the AMA in 1965 and 1966 urged state medical associations to recommend voluntary participation in IMPAC and AMPAC and that this participation be as universal as possible, and,

WHEREAS, the AMA House of Delegates urged the desirability of a common billing service to be provided by state medical associations whereby voluntary, non-deductible contributions be made to political action committees, and,

WHEREAS, many of our sister states have adopted this same policy,

NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates adopt the policy of including voluntary IMPAC and AMPAC contributions on all dues statements in an amount decided by these organizations."

Mr. Chairman, the committee approves this resolution and recommends its adoption, and I do so move.

(Motion seconded.)

(In answer to Dr. Schuster's editorial question, it was determined that "these organizations" mean IMPAC and AMPAC.)

Discussed by Drs. Willison, McClure, Wood and Shields.

Dr. Willison moved to amend the "Resolve" by adding the words "or mailed with" following the words "contributions on."

(Motion seconded, put to vote, and carried.)

The chairman read the "Resolve" as amended: "NOW, THEREFORE, BE IT RESOLVED, that this House of Delegates adopt a policy of including voluntary IMPAC and AMPAC contributions on or mailed with all dues statements in an amount decided by these organizations. (These organizations to mean IMPAC and AMPAC)."

(Dr. Petrich's motion to adopt this resolution as amended was seconded, put to vote, and carried.)

Resolution No. 67-8

Introduced by: FORT WAYNE
(ALLEN COUNTY)
MEDICAL SOCIETY

Subject: SURVEY OF ISMA
MEMBERSHIP RE-
GARDING SERVICES
OFFERED BY INDI-
ANA STATE MEDI-
CAL ASSOCIATION

WHEREAS, the Indiana State Medical Association has long been recognized as one of the most dynamic leaders in organized medicine, and,

WHEREAS, despite its apparent success, the Indiana State Medical Association should constantly evaluate its programs and objectives in order that they meet with the ever changing needs of its members,

NOW, THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association conduct an in-depth survey of the membership to find out the opinions of the services offered to them by the Indiana State Medical Association, and,

BE IT FURTHER RESOLVED, that the survey be conducted by an objective outside source, professionally trained in the techniques of opinion research.

Resolution No. 67-18

Introduced by: THE COUNCIL
Subject: SURVEY OF
MEMBERSHIP

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends to the House of Delegates of the Indiana State Medical Association that a survey be conducted of the membership of the Indiana State Medical Association for the purpose of evaluating programs and objectives for the future.

REFERENCE COMMITTEE ACTION

Dr. Petrich presented the following report:

The committee next considered resolutions #8 and 18 as dealing with the same subject. After considerable discussion on the part of many, the committee arrived at the conclusion that precipitous action relative to a survey of the membership was not warranted at this time. In lieu thereof, we recommend that the resolutions be referred to the Council for referral to the appropriate committee of the ISMA for further consideration as to the feasibility, cost and benefits to be derived from such a study; and that the component societies be urged to canvass their members to determine the interrelated needs and the responsibilities of those members and the Indiana State Medical Association.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Chairman of Blue Shield Board of Directors

DR. GLEN V. RYAN, chairman, Blue Shield Board of Directors, addressed the House as follows:

WHAT'S AHEAD FOR BLUE SHIELD?

The *real test* for Indiana Blue Shield in the years ahead is how well we serve our members and the rest of the people of Indiana. The immediate future holds a serious challenge, both to Blue Shield and to medicine. Where we go depends upon our capacity to determine what is needed in the area of health care financing, and upon our ability to furnish the public what is needed and wanted. If we don't develop and sell the required benefits at a price most people can afford to pay, it is probable that the government will attempt to extend its health care programs to cover most, if not all, of the population. Our only solution to that problem *is to continue* with the development of new programs to meet the demands of all those who are now protected by Blue Shield and by private insurance companies. We must continue to demonstrate to government and industry that we *can* do the job, and that there is no need for further government involvement in the health care field. The *basic needs* of the elderly and the medically indigent have been met.

Among the new programs that are being considered by Blue Shield Plans and the insurance industry you will find dental care, psychiatric care, home and office call coverage, preventive medicine, and prescription drugs. Indiana Blue Shield is ahead of the game in some of these areas, and has done some planning and investigating in the others. We have developed and will continue to develop new programs in anticipation of customer demand, so that industry can choose the one best suited to their needs from a variety of programs. Blue Shield and the medical profession want to play a strong role in selecting and developing these new programs, and in determining the manner in which such benefits will be provided.

A major problem is *how* we administer the new program for steel, which was effective August 1. Nationally one million steelworkers and their families are now covered by a new program of benefits which provides full reimbursement of reasonable charges for presently covered services, plus pre- and post-natal and in-hospital medical care. Recently Robert E. Rinehimer, vice president-sales, Pennsylvania Blue Shield, said: "The steel industry and union could care less whether we use prevailing fee, usual and customary, fair and reasonable, or other comparable terms. What they are primarily interested in is

the efficient delivery of goods. We have just one year to demonstrate our ability to handle the job. Our performance will be measured against that of other carriers." This approach is not much different from that of the automobile industry, and the telephone industry.

Indiana Blue Shield introduced a prepayment plan for dental expenses in 1965. It was developed cooperatively with the Indiana State Dental Association, and is being offered on a pilot basis through employers with 100 or more employees. The program includes a basic plan with a choice of two options that can be added to strengthen the benefit program.

Our home and office call program was offered on a pilot basis as early as 1952.

Some elements of psychiatric care are covered in most of our basic and major medical programs, but the development of a full psychiatric program is a task ahead. The same thing is true of preventive care.

Our first major medical program was offered in 1961, and had proved to be one of our strongest programs. Presently a major medical program is available to federal employees, doctors, lawyers and other major accounts. It is also available to our direct pay members, and the 65 and over who are protected by our Medicare Supplement program.

Since organization in 1946 Indiana has stressed the development of new and broader benefit programs, and this will continue in the period just ahead. The physicians of Indiana can do much to help us select the programs to be offered, and the method used to furnish the benefits.

If the practice of medicine and the prepayment mechanism are to remain in the private sector of the economy, Blue Shield with the assistance of physicians, must complete the job we have started, and continue to develop more comprehensive benefit programs of the type desired by the public, offered at a cost the public can afford to pay.

REFERENCE COMMITTEE ACTION

Dr. Petrich presented the following report:

The committee next discussed the report of Doctor Ryan and Blue Shield. We commend the professional quality of the report and receive it for information.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption, and I do so move.

(Motion seconded, put to vote, and carried.)

Legislation

The report of the Commission on Legis-

lation was reviewed by the committee and we wish to commend most highly this very able, unstinting and dedicated group of men who serve the association so constantly and so well.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Medical Economics and Insurance

The report of the Commission on Medical Economics and Insurance was reviewed and a correction of the report was made by a representative of Allen County relative to a statement in the report on lines 6 and 7, Section 3, page 120 in the Handbook. This section, "and Fort Wayne Medical Society" was stricken from the report as erroneous. The committee commends the commission highly on their endeavors in the insurance aspects of their activities, but feels that activities in medical economics, a no less important area, have been somewhat neglected.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Mr. Chairman, the committee recommends the adoption of this report as a whole as amended. I do so move.

(Motion seconded, put to vote, and carried.)

I again wish to thank all who participated in the hearings of this committee and especially my fellow members who worked on the committee, Drs. Bob Brown, Vince Santare, Dan Hare and Don Wood, who deserve a hearty "well done".

REFERENCE COMMITTEE NO. 4

The following matters were referred to Reference Committee No. 4. All reports will be found on the pages indicated in the September, 1967, Vol. 60, *Journal of the Indiana State Medical Association* with the exceptions herein noted.

The addresses of the president, the president-elect, and the report of the president of the Indiana Student AMA are printed in the December, 1967, *Journal*, on the pages listed.

The address of the president of the Woman's Auxiliary, and the resolutions introduced before the House and referred to this committee are printed herewith.

President's address (pages 1746-48, December, 1967, *Journal*)

President-elect's address (pages 1749-52, December, 1967, *Journal*)

Executive Secretary (pages 1223-26)

Treasurer (page 1227)

Chairman of Council (not printed in Sept., 1967, *Journal*; pages 86-87, Handbook)

Councilors' reports (pages 1227-29)

Journal Editor (pages 1229-30)

Delegates to AMA (pages 1230-34)

Address of President of Woman's Auxiliary

Executive Committee (pages 1235-37)

Address of President of Indiana Student AMA (pages 1753-54, December, 1967, *Journal*)

Commission on Constitution and Bylaws (page 1240)

Future Planning Committee (pages 1238-39)

Resolution No. 67-9—MANPOWER RECRUITMENT AND INDIANA HEALTH CAREERS, INC.

Resolution No. 67-11—MANPOWER RECRUITMENT AND INDIANA HEALTH CAREERS, INC.

Resolution No. 67-12—REFERENCE COMMITTEE REPORTS

Resolution No. 67-16—MEDICAL QUACKERY

Resolution No. 67-24—CLOSED HOSPITALS STAFFED BY SALARIED PHYSICIANS

Resolution No. 67-25—RECRUITMENT SERVICES OF INDIANA HEALTH CAREERS

Resolution No. 67-30—FUNDS FOR STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

President's Address

The address of the president, Dr. Eugene S. Rifner, is printed on pages 1746-48 of the December, 1967, *Journal of the Indiana State Medical Association*.

President-elect's Address

The address of the president-elect, Dr. G. O. Larson, is printed on pages 1749-52 of the December, 1967, *Journal of the Indiana State Medical Association*.

REFERENCE COMMITTEE ACTION

Dr. Wayne H. Endicott, in the absence of Dr. Dean B. Jackson, chairman of Reference Committee No. 4, presented the following report:

The committee studied the address of the president and agrees wholeheartedly with his comments and commends the president for his scholarly presentation.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

The committee wished to emphasize the

importance of improved communications between the component societies, district societies and the state association, particularly the importance of commission members conferring with the county societies. In addition, the committee also notes and approves Doctor Larson's desire for a resurrection of an annual Conference of County Medical Society Officers.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Executive Secretary

The executive secretary is commended particularly on his innovation of a pictorial presentation of the activities of the association, as presented in his report.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Treasurer

The committee approves the treasurer's report, as printed on Page 86 of the Handbook and recommends its adoption.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Chairman of Council

The committee approves the report of the chairman of the Council, as presented on pages 86 and 87 of the Handbook and recommends its adoption.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Reports of Councilors

The committee commends those councilors who submitted reports and hopes that the absence of reports from the remaining districts does not reflect the degree of activity in these areas. We recommend the adoption of this portion of the report.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Editor of The Journal

The committee commends the editor and editorial staff of *The Journal* for their excellence in producing a publication that

rates among the finest of its kind in this country. We move the adoption of the report of the editor of *The Journal*, as printed on pages 92 and 93 of the Handbook. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Delegates to AMA

The committee commends the delegates to the AMA for their detailed report and wholehearted effort on behalf of ISMA, as exemplified by their perfect attendance record at the meeting of the AMA delegates. We recommend the report as written on pages 93-101 be filed.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Woman's Auxiliary Presidential Address

MRS. JOHN W. DEEVER, Indianapolis, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

Dr. Rifner, distinguished guests and members of the House of Delegates: The 39th year of the Woman's Auxiliary to the ISMA came to a close following the April House of Delegates meeting in Evansville.

Under the able leadership of Mrs. Alfred Scales, our 1966-67 president, the state auxiliary has continued to move forward, carrying out the objectives of our organization. In Mrs. Scales report to the national auxiliary House of Delegates which convened in Atlantic City, June 1967, the following achievements were cited:

Our membership for the year totaled 2,874; 74 of these members were MAL's (members-at-large). MAL's are doctor's wives who pay dues to the Indiana state and national auxiliary and yet do not have a county auxiliary affiliation, usually because the county is too small to organize. We appreciate the interest expressed by these ladies in the state organization.

Our Health Careers chairman, in response to the urgent need for recruiting in the health fields, placed a copy of "Opportunities Unlimited" in the office of every physician. This book describing job opportunities and educational requirements in all fields related to health needs is obtained through Indiana Health Careers, Inc., of which we are a member organization. Many counties also placed this book in their local schools and public libraries. A total of \$14,300 was made available in loans and scholarships by the county auxiliaries to worthy and needy

students who are being educated in health fields.

International Health Activities is a large program in our auxiliary. Many tons of drug samples, medical and surgical supplies, used medical textbooks and journals, bandages, johnny coats, baby dresses and layettes were collected and sent to World Medical Relief and Santa Barbara for shipment overseas.

In the field of mental health, 50 of our 57 counties reported activity. One county placed a booklet "Indiana Psychiatric Care, Treatment and Rehabilitation" in the offices of their county physicians.

The auxiliary, through its Safety Disaster Preparedness chairman, helped to promote the viewing audience for a 15 week series of TV programs on "Medical Self-Help" which were shown in central Indiana. In addition, one county presented the "Patch on Pony" program to each child from kindergarten through grade three, providing information on child molesters.

The Indiana physicians can be justly proud of their wives in the field of community service. Many hours of dedicated service are given through volunteer service in hospitals and health agencies. Two programs of Meals-on-Wheels, in cooperation with other organizations, are getting underway.

Our state budget provides that each county legislative chairman shall receive "Legislative Round-up." This report plus the efforts of our state legislative chairman has kept the auxiliary alert in political action.

Four-fifths of our organized counties contributed to AMA-ERF for a total contribution to the national program of \$19,125 for an average contribution of \$6.65 per member. This again won Indiana the national award (a plaque) for state auxiliaries in the membership category of 2,001-3,000. Vanderburgh-Southwestern auxiliary also won the national achievement award for local auxiliaries with a membership of 101-200. Their per capita contribution was \$18.25.

The Hoosier Doctor's Wife continues to be published four times a year. Jean Green, our editor, remains on the staff as a contributing editor of our national publication *The M.D.'s Wife*.

Our 40th year of auxiliary work is now half gone. This year we are operating on a budget of \$7,234.00.

Our leadership was happy to be invited to a most inspiring IMPAC workshop on Sunday, September 10th. We feel that the more knowledgeable we are, the more effective we become in service to the ISMA.

The Indiana State Auxiliary Workshop is

now history. This very excellent meeting was held September 20th at Indiana Central College, Indianapolis. Twenty-four auxiliaries were represented with a total registration of 69.

This year there is once again a conflict with dates between the ISMA convention and our National Auxiliary Conference for State Presidents and Presidents-elect, which is being conducted in Chicago. I have remained here for most of the convention activities and our president-elect is representing us at the conference.

It is a pleasure to serve as president of the WA-ISMA, because we meet the nicest ladies in the state of Indiana—the doctor's wife—and because we are blessed with the splendid cooperation and guidance of Dr. Rifner, Dr. Everly, the advisory Council and the ISMA staff under the direction of Mr. James Waggener. We thank all of you for your continued interest in the auxiliary.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

This committee commends Mrs. Roberta Deever for the information report on the activities of the Woman's Auxiliary and recommends that the report be filed.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Executive Committee Report

The committee approves the Executive Committee report, as printed on pages 102-107 of the Handbook and takes a special note of the desire of the Executive Committee to extend sincere thanks to the Woman's Auxiliary.

It was also noted that the committee took action to make the final payment on the headquarters building and feels that this achievement should be called to the attention of the House of Delegates.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Report of Indiana Student AMA

The report of the Student AMA delegate was heard with interest at the first meeting of the House and the committee feels that since there was no written report submitted, we cannot make recommendations as to adoption but we do recommend that any transcription of the report, as delivered, be filed.

Mr. Chairman, the committee approves

this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Constitution and Bylaws

The committee recommends the adoption of the first portion of the report of the Commission on Constitution and Bylaws, which incorporates the following change in the Bylaws, Chapter VII, Section 1: "The Council shall meet as follows: 1. The Council shall meet at least once each quarter of the calendar year; the time, date and location to be fixed by the Council." The remainder of Section 1, Chapter VII remains unchanged.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

The second portion of the report of the Commission on Constitution and Bylaws consists of proposed amendments to the Constitution. We approve these proposed amendments subject to their publication in *The Journal* twice in the coming year and final consideration at the 1968 meeting of the House of Delegates. These amendments follow:

"ARTICLE VI-BOARD OF TRUSTEES"

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except in the absence of his Trustee; and (2) *ex-officio*, the President, President-elect, Treasurer with power to vote and Assistant Treasurer without power to vote except in case the Treasurer be absent. Besides its duties mentioned in the Bylaws, the Board of Trustees shall have full charge and control of all the property of the Association."

The balance of the Article to remain unchanged.

Be it further resolved that the following amendments be made to the remainder of the Constitution:

(1) Substitute the words "Board of Trustees" in lieu of the word "Council" wherever said word appears therein. (2) Substitute the word "Trustees" in lieu of the word "Councilors" wherever said word appears therein. (3) Substitute the word "Trustee" in lieu of the word "Councilor" wherever said word appears therein.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Future Planning Committee

Mr. Chairman, the committee commends

the report of the Future Planning Committee in which it is pointed out that the emphasis on improved communication should be continued, as has been recommended by our president-elect.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-9

Introduced by: TRUMAN E. CAYLOR, M.D., BLUFFTON, DELEGATE, WELLS COUNTY
Subject: MANPOWER RECRUITMENT AND INDIANA HEALTH CAREERS, INC.

WHEREAS, an increasing number of individual members of ISMA cooperate with and wholeheartedly endorse the program of Indiana Health Careers, and,

WHEREAS, many individual members of ISMA who accept responsibilities for recruitment in their local areas depend upon Indiana Health Careers for staff services, literature and mailing, and,

WHEREAS, Indiana Health Careers has since 1961 implemented a well organized program of recruitment and maintains a service to school counselors which supplies current resource materials about more than 200 health careers, related manpower information, workshops, speakers, displays, etc.,

NOW, THEREFORE, BE IT RESOLVED, that, inasmuch as there is direct benefit to the members of ISMA resulting from these services, \$1,000.00 be granted Indiana Health Careers, initially, and,

BE IT FURTHER RESOLVED, that a committee be named to 1). plan for continued cooperation with Indiana Health Careers 2). determine the degree of financial responsibility indicated.

Resolution No. 67-11

Introduced by: JACK W. HICKMAN, M.D., INDIANAPOLIS, DELEGATE, MARION COUNTY
Subject: MANPOWER RECRUITMENT AND INDIANA HEALTH CAREERS, INC.

WHEREAS, an increasing number of individual members of ISMA cooperate with and wholeheartedly endorse the program of Indiana Health Careers, and,

WHEREAS, many individual members of ISMA who accept responsibilities for recruitment in their local areas depend upon Indiana Health Careers for staff services, literature and mailing, and,

WHEREAS, Indiana Health Careers has since 1961 implemented a well organized program of recruitment and maintains a service to school counselors which supplies current resource materials about more than 200 health careers, related manpower information, workshops, speakers, displays, etc.,

NOW, THEREFORE, BE IT RESOLVED, that, inasmuch as there is direct benefit to the members of ISMA resulting from these services, \$1,000.00 be granted Indiana Health Careers, initially, and,

BE IT FURTHER RESOLVED, that a committee be named to 1). plan for continued cooperation with Indiana Health Careers 2). determine the degree of financial responsibility indicated.

Resolution No. 67-25

Introduced by: WAYNE-UNION COUNTY MEDICAL SOCIETY
Subject: RECRUITMENT SERVICES OF INDIANA HEALTH CAREERS

WHEREAS, members of ISMA are most intimately concerned with the health manpower problem, and,

WHEREAS, Indiana Health Careers has developed a well promoted actively maintained program to recruit to medicine and its allied fields, and,

WHEREAS, individual members of ISMA throughout the state seek the services of the Indiana Health Careers staff, secure career recruitment pamphlets and information at no cost and cooperate extensively in other coordinated recruitment efforts (e.g., workshops),

NOW, THEREFORE, BE IT RESOLVED, that ISMA contribute \$1,000 in recognition of services and materials directly and indirectly benefiting its members, and,

BE IT FURTHER RESOLVED, that Indiana State Medical Association emphasize and pursue in cooperation with Indiana Health Careers a coordinated recruitment program.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

In addition to the addresses and reports, there were seven resolutions referred to Reference Committee Number 4.

Resolutions #9, #11 and #25 were all concerned with recruitment service of Indiana Health Careers and the three were considered as No. 9.

General approval was heard for the res-

olutions; however after hearing the suggestions of the physicians, the committee feels that the following amendments are indicated:

One, a reduction in the contribution to \$500.00;

Two, deletion of the word "initially", and

Three, rewording the second portion of the resolution to read as follows: "Resolved, further that the question of continued support by ISMA be referred to the Commission on Inter-Professional Relations and also the resolution be referred to the Executive Committee and Council for approval of the budget before final action is taken thereon.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-12

Introduced by: THE COUNCIL
Subject: REFERENCE COMMITTEE REPORTS

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends a change in the policy as adopted by the House of Delegates in 1963 which requires reference committee reports to be available to delegates 24 hours in advance of the final meeting of such House by deleting the number "24" and substituting in lieu thereof the number "12."

BE IT FURTHER RESOLVED, that such Council submit this resolution to the House of Delegates and recommend its approval by such body.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

The next resolution to be considered was #12 pertaining to the reference committee reports. After hearing testimony from several interested physicians, it was obvious that a compromise between 24 and 12 hours was necessary and advisable and we recommend that Resolution #12 be amended to read as follows:

"BE IT RESOLVED, that completed reference committee reports be available to Delegates by 4:00 p.m. the day preceding the final meeting of the House of Delegates."

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-16

Introduced by: THE COUNCIL
Subject: MEDICAL QUACKERY

BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association recommend to the Commission on Legislation that it prepare, introduce and seek passage of legislation in the next meeting of the Indiana General Assembly making medical quackery a felony in the state of Indiana.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

Resolution #16 concerning medical quackery was discussed by several physicians. Due to redundant wording, we recommend that Resolution 16 be amended by omitting the words, "The Council of the Indiana State Medical Association hereby recommends."

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-24

Introduced by: THE COUNCIL
Subject: CLOSED HOSPITALS STAFFED BY SALARIED PHYSICIANS

WHEREAS, the increasing involvement of medicine in Medicare and Medicaid will augment the use of hospitals for diagnostic and other procedures, and,

WHEREAS, under the guise of "economy," government agencies, hospitals, and other groups may find it feasible to offer a "package" type of care by creating closed institutions staffed entirely by salaried personnel, and,

WHEREAS, such arrangements would create in-hospital and out-of-hospital classes of doctors, and,

WHEREAS, exchange of ideas among physicians is in the best interest of better patient care, and,

WHEREAS, the Federal government, the AMA, and educators in the universities are recognizing the important position of the private practicing physician in the future of medicine,

NOW, THEREFORE, BE IT RESOLVED, that the Council of the Indiana State Medical Association hereby recommends that the House of Delegates of the Indiana State Medical Association express

its disapproval of the establishment of closed hospitals or clinics staffed entirely by salaried physicians and that all recognized specialty groups and boards and the AMA be informed of this action.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

The committee recommends amending Resolution No. 24 to read:

"NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the ISMA express its disapproval of the future establishment of closed hospitals or clinics staffed entirely by salaried physicians and that all recognized specialty groups and boards and the AMA be informed of this action."

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded.)

Dr. Hickman's motion to amend the resolution by striking the words "or clinics" was seconded, discussed by Dr. Caylor, put to vote, and carried.

Dr. Dalton offered an amendment to the amendment of Resolution No. 67-24, as follows, and moved its adoption:

"This House of Delegates approves in principle this amended resolution. Due to the urgency of this problem and the multiple ramifications thereof and the need for further clarification, the House of Delegates refers the matter, in its entirety, to the Council for implementation."

(Motion seconded, put to vote, and carried.)

Dr. Endicott, acting chairman, continued with the report of Reference Committee No. 4.

Mr. Chairman, the committee approves this portion of the report as amended, and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

Resolution No. 67-30

Introduced by: THE COUNCIL
Subject: FUNDS FOR STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

BE IT RESOLVED, that the Indiana State Medical Association support and encourage the Indiana State Board of Medical Registration and Examination to use the new multiple testing procedure as developed by the Federation of State Medical Boards for testing applicants for medical license to practice in Indiana, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association urge the Indiana legislature to appropriate sufficient funds to the medical board to conduct the board in a manner as prescribed by law and to allow them to conduct this new type of examination.

REFERENCE COMMITTEE ACTION

Dr. Endicott, acting chairman, presented the following report:

Regarding Resolution #30 subject, FUNDS FOR STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION, more testimony was heard on this resolution than any other. It was evident that more money was needed to update the testing procedure for applicants for medical license in Indiana. However, caution was urged in not advising a premature change that could open the Medical Practice Act.

Consequently, the resolution was divided into two parts—one for amendment and one for referral.

The first part to be amended as follows:

"BE IT RESOLVED, that the Indiana State Medical Association encourage the Indiana State Board of Medical Registration and Examination to investigate new testing procedures for testing applicants for medical license to practice in Indiana."

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

It was felt by the committee that Part 2 of the original Resolution #30 should be referred to the Commission on Medical Education and Licensure for their further study and re-submission to the House for its action prior to the next meeting of the State Legislature in 1969.

Mr. Chairman, the committee approves this portion of the report and recommends its adoption. I do so move.

(Motion seconded, put to vote, and carried.)

I wish to take this opportunity to thank the members of the committee for their diligent work.

Mr. Chairman, the committee approves this report as a whole as amended, and I do so move its adoption.

(Motion seconded, put to vote, and carried.)

ELECTION OF OFFICERS

The following officers were elected:

President-elect—Patrick J. V. Corcoran, M.D., Evansville

Treasurer—Lester H. Hoyt, M.D., Indianapolis

Assistant Treasurer—Malcolm O. Scamahorn, M.D., Pittsboro

AMA delegates and alternates for term expiring December 31, 1969:

Delegates:

Guy A. Owsley, M.D., Hartford City
Jack E. Shields, M.D., Brownstown

Alternates:

Maurice E. Glock, M.D., Fort Wayne
Dwight W. Schuster, M.D., Indianapolis

Resignation of Dr. James H. Gosman, Indianapolis:

Dr. James H. Gosman's resignation as AMA alternate delegate was accepted by the House.

Dr. Don E. Wood, Indianapolis, was elected to fill Dr. Gosman's unexpired term, ending December 31, 1968.

ADDRESS OF PRESIDENT-ELECT

Mr. President, members of the House, and friends: I have watched this little ritual many times in the past and I never really believed that this would happen to me. I am deeply grateful to you for entrusting this office to me, with its challenges and its opportunities. My thanks go to my friends throughout the state, especially Evansville and the First District, for the generous support and effort, the advice and buoying up that you have given me for a long time. I am sure that there are many who can serve in this office with more grace or more ability, and chastened with that realization, I pledge my best in your service. Thank you.

Places of Future Annual Conventions

Dates and places previously set:

1968—Fort Wayne, week of October 14

1969—Indianapolis

1970—Evansville

1971—Indianapolis

1972—On motion of Dr. Black, seconded by many, the invitation to hold the 1972 annual convention in French Lick was accepted.

Oath of Office

Dr. Rifner turned the gavel over to Dr. Larson, president 1967-68, who administered the oath of office, in accordance with Chapter V, Section 5, of the Bylaws, to all newly-elected officers, councilors and alternate councilors, as follows:

Patrick J. V. Corcoran, president-elect;
Lester H. Hoyt, treasurer; Malcolm O. Scamahorn, assistant treasurer; councilors: Donald M. Kerr, Third District; Stephen

D. Smith, Sixth District; Peter R. Petrich, Ninth District; William R. Clark, Twelfth District; alternate councilor, Frederic L. Schoen.

Resolutions of Appreciation

Dr. Thomas G. Hamilton presented the following resolution which was adopted unanimously:

Appreciation of President

WHEREAS, the office of president of the Indiana State Medical Association is one which demands time, conscientious effort, and steadfast loyalty to the profession, and,

WHEREAS, the Indiana State Medical Association has, through the leadership of its president for 1966-67, witnessed a forceful demonstration in the fulfillment of the demands of the office, and,

WHEREAS, such leadership has strengthened the total effect of organized medicine in Indiana and the nation,

NOW, THEREFORE BE IT RESOLVED, that this House of Delegates convey to Dr. Eugene S. Rifner its heartfelt thanks for carrying on his presidential duties with dignity and purpose for the betterment of the profession.

Dr. Dwight W. Schuster presented the following resolution which was adopted unanimously:

Appreciation of Commission on Convention Arrangements

WHEREAS, the successful execution of any convention requires long hours of work and good planning, and,

WHEREAS, the 1967 convention of the Indiana State Medical Association has been extremely successful and well conducted,

NOW, THEREFORE BE IT RESOLVED, that this House of Delegates express its sincere appreciation to Dr. Richard B. Hovda, chairman of General Convention Arrangements, and his commission, and to Dr. William M. Kendrick and Dr. Durward W. Paris and their Committee on Entertainment, for an outstanding job; and,

BE IT FURTHER RESOLVED, that this House express its appreciation to the state's press, radio and television for their coverage of the meeting, and to the management of the Columbia Club, the Murat Temple, the Athenaeum, and the Indianapolis Athletic Club for their cooperation and assistance in making the meeting a success.

Adjournment

The House of Delegates adjourned, *sine die*, at 12:20 p.m., Thursday, October 12, 1967. ◀

Association News

EXECUTIVE COMMITTEE

October 8, 1967

Present: Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Eugene S. Rifner, M.D.; G. O. Larson, M.D.; Lowell H. Steen, M.D.; Lester H. Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert E. Robinson, attorney, and James A. Waggener, executive secretary.

Membership Report

Number of members as of	
December 31, 1966	4,409
1967 members as of	
September 30, 1967:	
Full dues paying	3,866
Residents and interns	115
Council remitted	53
Senior	308
Honorary	3
Military	48
Total 1967 members as of	
September 30, 1967	4,393
Number of members as of	
September 30, 1966	4,381
Gain over last year	12
Number of AMA members as of	
September 30, 1967	4,223
Total 1966 AMA members as of	
September 30, 1966	4,268
Loss over last year	45
1967 AMA members:	
Dues paying	3,697
Exempt, but active	526
	4,223
Number who have paid state dues but not AMA dues as of	
September 30, 1967	170

Headquarters Office

A proposal from a group travel organization concerning the Indiana State Medical Association sponsoring a tour similar to that taken by the Indiana State Bar Association was discussed. On motion of Drs. Steen and Rifner, it was determined that the association should not sponsor such a tour.

Treasurer's Office

The treasurer's report was given by Dr. Hoyt, and on motion of Drs. Hoyt and Steen, the report was approved.

Legislation

National: The attorney gave a progress report on federal planning.

Organization Matters

A letter from Dr. F. J. L. Blasingame concerning the recent visit of the Council to the AMA headquarters office was read and on motion of Dr. Steen, taken by consent, the secretary is to write Dr. Blasingame

game thanking him for the hospitality extended by the AMA.

A letter from Blue Shield concerning the vacancy on the Board of Directors, caused by the death of Dr. C. Philip Fox, Second District, was read. On motion of Drs. Steen and Larson, the committee voted to recommend to the Council that the Council, in turn, recommend to the Blue Shield Board that Dr. Joseph Dukes of Dugger be elected to fill the unexpired term of Dr. Fox.

A memorandum from the Commission on Medical Education and Licensure in which Dr. Merritt O. Alcorn stated his willingness to appear before the Council to discuss the proposed new examination method under study by the State Medical Board was reviewed, and on motion of Drs. Steen and Rifner, it was voted to notify Dr. Alcorn to discuss this before the Council.

Minutes of the meeting of the Commission on Inter-Professional Relations, held September 17, 1967, were called to the attention of the committee for its information.

A letter from the Indiana Hospital Association under date of September 20 concerning pre-admission testing was called to the attention of the committee and the matter was taken as information.

Request of the Board of Health concerning the inclusion of information in the News Flash was reviewed and by consent it was felt that the State Board of Health should send this information to physicians.

A newspaper item concerning the Michigan State Medical Society accepting an osteopath into membership was read for the information of the committee.

The Journal

A letter from Carl Byoir & Associates, Inc., New York, was discussed by Dr. Ramsey and his use of this material was approved by consent.

New Business

A letter from Ball State University concerning a proposed seminar in 1968 dealing with drug abuse was reviewed, and on motion of Drs. Rifner and Steen, the secretary is to inform Ball State University that the association will cooperate in this effort.

The proposal of the Service Bureau Corporation for computerized billing was reviewed and no action was taken pending the action of the House of Delegates.

The attorney discussed matters relating to Morgan and Elkhart counties for the information of the committee.

The matter concerning the Committee on Economics and group practice, etc., was ordered placed on the agenda of the next

meeting of the Executive Committee for discussion.

Future Meetings

AMA meeting at Houston. By consent it was decided that the hospitality room will be operated from 5:00 to 7:00 p.m. On motion of Dr. Rifner, taken by consent, the chairman of the council is to assign those responsible for the hospitality room each day it is open.

The Executive Committee and delegates' meeting was scheduled for 6:00 p.m. Saturday night at the Shamrock-Hilton Hotel.

The delegates' breakfasts were scheduled for 7:30 a.m. on Monday, Tuesday and Wednesday.

The request of the AMA for representatives to be sent to the National Planning Conference on Health Care of the Poor, Chicago, December 15-16, 1967, was reviewed and on motion of Drs. Rifner and Steen, two representatives are to be sent; one shall be the president and the other a person of his choice.

There being no further business the committee adjourned, to meet again at the conclusion of the final meeting of the House of Delegates on Thursday, October 12.

EXECUTIVE COMMITTEE

October 12, 1967

The Executive Committee convened following the close of the Council meeting on Thursday, October 12, 1967, in the Ballroom of the Columbia Club, with the following members present:

Ralph V. Everly, M.D., chairman; Burton E. Kintner, M.D.; Patrick J. V. Corcoran, M.D.; G. O. Larson, M.D.; Lowell H. Steen, M.D.; Lester H. Hoyt, M.D., and Malcolm O. Scamahorn, M.D.

James A. Waggener, executive secretary.

Dr. Corcoran was welcomed as the new president-elect of the association and a new member of the Executive Committee.

Dr. Hoyt was welcomed as the new treasurer, and Dr. Malcolm O. Scamahorn as the new assistant treasurer.

By secret ballot, Dr. Ralph V. Everly was elected chairman of the Executive Committee for the year 1967-1968.

The appropriate officers signed the bank resolutions and the bank signature cards.

There being on further business the committee adjourned to meet again at 4:00 p.m., Saturday, November 18, 1967.

THE COUNCIL

October 9, 1967

The Council convened at 7:30 a.m., Eastern Standard Time, Monday, October 9, 1967, in Parlor A of the Columbia Club, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:

Councilors:

- First District—Patrick J. V. Corcoran, Evansville
Gilbert M. Wilhelmus, Evansville, alternate
- Second District—Joe Dukes, Dugger
Betty Dukes, Dugger, alternate
- Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
- Fifth District—Wilbert McIntosh, Riley
C. M. Schauwecker, Greencastle, alternate councilor-elect
- Sixth District—William R. Tindall, Shelbyville
Stephen D. Smith, Knightstown, councilor-elect
- Seventh District—Albert M. Donato, Indianapolis
- Eighth District—Donald R. Taylor, Muncie
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Herman Wing, Gary, alternate
- Eleventh District—Lowell J. Hillis, Logansport
James A. Harshman, Kokomo, alternate
- Twelfth District—William R. Clark, Fort Wayne, alternate and councilor-elect
Frederic L. Schoen, Fort Wayne, alternate councilor-elect
- Thirteenth District—Otis R. Bowen, Bremen
George B. Gattman, Elkhart, alternate

Officers:

- Eugene S. Rifner, Van Buren, president
G. O. Larson, LaPorte, president-elect
Lester H. Hoyt, Indianapolis, assistant treasurer

Journal:

- Frank B. Ramsey, Indianapolis, editor

Executive Committee:

- Ralph V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Guests:

- Harold C. Ochsner, Indianapolis, AMA delegate
Eugene F. Senseny, Fort Wayne, AMA delegate
Guy A. Owsley, Hartford City, AMA delegate

- James H. Gosman, Indianapolis, AMA alternate delegate
Robert M. Brown, Marion, AMA alternate delegate
Kenneth O. Neumann, Lafayette, AMA alternate delegate
Dwight W. Schuster, Indianapolis, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, I.U. School of Medicine
Lester D. Bibler, Indianapolis, AMA Trustee
Richard B. Hovda, Evansville, chairman, Convention Arrangements
Glen V. Ryan, Indianapolis, chairman, Blue Shield Board
Merriitt O. Alcorn, Jr., president, State Board of Medical Registration and Examination
W. J. Brown, Chicago, AMA field representative

Staff:

- Robert Robinson, attorney
James A. Waggener, executive secretary
The following were absent:

Councilors:

- Twelfth District—Milton F. Popp, Fort Wayne

Alternate Councilors:

- Third District—E. L. Wallace, New Albany
Fifth District—A. W. Cavins, Terre Haute
Sixth District—Frank H. Green, Rushville (also AMA delegate)
Seventh District—John O. Butler, Indianapolis
Eighth District—Paul W. Sparks, Winchester
Ninth District—Clarence G. Kern, Lebanon

On motion of Drs. Petrich and Kerr, minutes of the meetings of July 30, 1967, and September 17, 1967, were approved as printed.

Reports of Councilors

DR. DUKES, Second District, reported that Dr. C. Philip Fox, of Washington, had passed away on September 20, 1967. Dr. Fox was a member of the Blue Shield Board of Directors from the Second District; his term would have expired in March, 1969.

DR. TINDALL, Sixth District, introduced Dr. Stephen Smith, Knightstown, councilor-elect of the Sixth District.

DR. STEEN, Tenth District, reported on a recent meeting of the Lake County Medical Society, at which Drs. Larson, president-elect, Bowen and Kerr, and Howard Grindstaff, field secretary, were present.

DR. CLARK, Twelfth District, introduced Dr. Frederic Schoen, alternate

councilor-elect of the Twelfth District.

DR. BOWEN, Thirteenth District, reported on the meeting of the Thirteenth District Medical Society which was held September 27, with an attendance of some 150. Drs. Rifner and Howard, of the AMA and Mr. Robinson were the speakers.

Reports of Guests

DR. GLENN W. IRWIN, Jr., Dean, Indiana University School of Medicine: During the past year this association and the I.U. School of Medicine have worked for a variety of new programs that in my opinion should help Indiana become a leader in several areas of medical education and medical service. A major change in curriculum was finally approved by the faculty, and the 1967 Indiana General Assembly endorsed the I.U. Plan for State-wide Medical Education, and provided the funding of 2.5 million dollars for two years beginning July 1, 1967. A Regional Medical Program planning grant was made to Indiana and an important project to study and do research in the field of delivery of health care was recently made possible by substantial support from the Regenstrief Foundation.

May I report some highlights of the 1967 freshman medical school class. Two-hundred and twenty one students were enrolled at our school of medicine, 205 enrolled at the Indianapolis campus and 16 enrolled at the Bloomington campus. These 221 students were picked from 1,011 applicants. Four hundred and thirty eight of these applicants were from Indiana and 573 applicants were non-residents. Of those taken from Indiana, 55 counties were represented. You would be interested to know that there were 20 women in this class. The Indiana applicants came from 19 schools in Indiana. Indiana University led the list with 98, Purdue was second with 19, followed by Butler with 9, Wabash with 9, Ball State with 7, DePauw with 5, and Indiana State with 7, and then a scattering from the other schools. Indiana and out-of-state students attended 27 different schools other than the 19 Indiana schools. This year only 14 out-of-state students were accepted. More were given an offer to come to Indiana but, as you know, many rejections occur from the out-of-state group. You might be interested to know the father's occupation in the case of students accepted. Small business led the list with 36, and business executives were second with 32. Following these were laborers—23; white collar persons—20; physicians—15; farmers—12, and skilled labor—12. The age of the students of this class ranged from 19 to 29 years. One hundred and fifty eight of the 221

were either 21 or 22 years of age.

The average premedical scholastic performance for the class was 3.1 (slightly above B). The range, however, was 4.0 (A) to 2.6 (C+). An analysis of Indiana students is quite important. Of the 438 applicants from Indiana, 35 did not complete their application. This left 403 Indiana candidates on which we had complete data. Of these 403 applicants, 71 had academic records below 2.5 and none of this group was accepted. This left 332 applicants who did have minimal to excellent qualifications. Nineteen of these, however, withdrew before any committee action was taken, which left a pool of 313 candidates for the admissions committee to consider. Of this group, 239 were offered placement in the class, but only 207 accepted.

Many of those not accepting a position in this class went to other medical schools, whereas others went to graduate school or took another year of undergraduate work. There were 74 Indiana candidates who at least had minimal general academic records and who were rejected. Most of these 74 students had general averages of 2.5, science averages under this, and low grades on the Medical College Admissions Test. Possibly 25 Indiana students were eligible for admission to our school but did not find a position. I would predict that at least half of these 25 students will be admitted next year. Many of them made application after three years of college or before they had a baccalaureate degree. Of the Indiana students not accepted at the I.U. School of Medicine, only three found places in other schools of medicine. The criteria and requirements for admissions seem similar in the majority of medical schools.

The association and the school have played a vital role early this year in our obtaining the statewide plan for medical education. There are two parts or sections of the plan, at least from a budgetary and functional standpoint. The General Assembly funded 2.5 million dollars for the biennium beginning July 1, 1967. One and one-half million dollars was allocated for the Indiana University School of Medicine to provide grants-in-aid to hospitals for educational purposes, to provide statewide faculty, and to provide communications and library output.

The other one million dollars, to be administered by the Board of Medical Education, was to provide partial payment for interns and residents, as well as certain postgraduate courses. The plan has been implemented. Fifteen color tape recorders and monitors have been purchased and placed in hospitals throughout Indiana. This communication equipment is in the

following cities: Indianapolis, Muncie, South Bend, Fort Wayne, Gary, Terre Haute, Evansville, Lafayette, and Marion. The television tape recorders have some advantages over live television in that they can be played at the convenience of the group that wishes to hear them, and the hospitals can select what they want to program. Tapes of medical subjects are available from various sources, and the school of medicine is now producing tapes for distribution.

Methodist Hospital in Indianapolis and Memorial Hospital in South Bend have television cameras and can make their own tapes. Grants-in-aid to support the educational aspects of this program have been made or negotiations are well along in the following cities or hospitals: Methodist Hospital, Indianapolis; Marion County General, Indianapolis; St. Vincent's, Indianapolis; Ball Memorial, Muncie; Memorial, South Bend; St. Joseph's, South Bend; Methodist, Gary; St. Mary's, Evansville; Fort Wayne, Terre Haute, and Lafayette. Financial aid is being provided to support directors of medical education and faculty who can conduct good educational programs for medical students, interns, and residents.

At the present time we have encumbered over one half million dollars from the Indiana University part of this bill to strengthen the educational and the communication network throughout the state. One of the concerns I have is that we have not recruited actively enough for interns for July, 1968. The current senior medical class is now selecting internships for next year. I have met with this class several times, as well as the directors of medical education of the state, to encourage them to consider internships in Indiana.

Surrounding states are actively recruiting by sending former I.U. medical graduates to interview these students. The Medical Education Board intends to stress the importance of this activity during the annual meeting of the Indiana State Medical Association. We must all support our own institution which has approved internships and residencies. The total number of interns in Indiana this year is 119, compared to 104 last year. We estimated the presence of 145 interns in Indiana during 1968-69. The total number of residents in Indiana this year is 288 compared to 277 last year. Our estimate for next year is 325. We have a real challenge to meet these goals. Thank you.

In answer to Dr. Donato's question regarding implementation of the curriculum on medical economics, Dr. Irwin said: The new curriculum has not been developed in this particular area. There are several aspects of the curriculum that have

not been completed; however, a phasing of new elements of the curriculum begins this academic year. Second year medical students will take Introduction to Clinical Medicine in January of 1968. This means they have six months bridge between the basic sciences and the clinical sciences. Physical diagnosis, laboratory medicine, radiology, pathology, medical jurisprudence and economics, and other subjects will be included in Introduction to Clinical Medicine.

Next year we will implement the core clinical material for third year students so that the following year, fourth year students will have much free time to be in various programs throughout the state. This does not mean there will not be a considerable number of our medical students taking work for credit in the hospitals and in the doctors' offices this year.

On motion of Drs. Kerr and Petrich the Council approved Dr. Irwin's suggestion that he submit for publication in *The Journal* an annual dean's report on medical school matters.

Dr. Clark's motion that "the Council commend the Dean and announce that we are in full support of the programs of the Indiana University School of Medicine" was duly seconded, put to vote, and carried.

Drs. Kerr and Owsley discussed the above subject. Dr. Owsley called attention to an article in the October 8 *The Indianapolis Star*, from which he quoted, "There's a deep division among Hoosier physicians over what the proper course should be for American and Indiana medicine. This article talked about it. Until this division is resolved, the Indiana State Medical Association will not be able to take a sound leadership role in the development of the Indiana Health Care System." Now, I think this should be answered some way.

It was taken by consent that the president of ISMA should call a press conference and categorically refute the allegation made in the article in *The Star*.

The Indiana Plan was discussed further by Drs. Irwin, Corcoran, Petrich and Hillis.

DR. GLEN V. RYAN, chairman, Blue Shield Board: Mr. Chairman, members of the Council, and guests: I am just going to make a few comments this morning as I will report to the House of Delegates this afternoon in more detail. The steel program in Lake County seems to be going along very well, according to the reports that I have received.

You are always interested in one item, I know, from Blue Shield, and that has to do with the length of time that the

claims are going through. As of last Friday, when a survey was made, 74% of the regular claims were going through in eight days, 80% in less than ten days. On the Medicare claims, the average is 15 days, and 65% are through in ten days or less.

Reports of Officers

DR. EUGENE S. RIFNER, President: Not too much has gone on in my office since our meeting in Chicago. I did attend the Marion County President's Ball and went to South Bend, as Dr. Bowen mentioned.

I told Lowell Steen this afternoon I think it is very important that we be sure that those of our people who are in advisory capacities on the advisory council for regional planning, be—I started to say commanded, I think that's just the right word—to report to this Council rather frequently. I think this is important. I think this thing could get way out of hand, way off in a corner if you people aren't constantly made aware of what's going on, especially in this areawide planning bill. I realize that Mr. Robinson is working for this—advising the Council at these meetings, and I think that the reports from these people certainly are in order.

As to the newspaper articles, I understand this man has been incorrect on several occasions. Because I think either last year or the year before last—this man reported in *The Star* that the Indiana State Medical Association was run by old men. The only gray haired man in the bunch was Kenny Neumann. So if he had been in error before—and I think if we get a chance to see him we will remind him of both those errors—I think that the state medical association, I'm sure that the Dean will concur, had a lot to do with helping get this Indiana plan through as we put it before the physicians in Indiana. And I was a little appalled when I read that because I thought, well this is fine, here you are, you're the president and you don't know what the rift is about.

The other thing in that article, if you read the last paragraph, he makes some scaly remark about how do you get all those people together. I suppose he meant this confidentially but I didn't take it so.

DR. G. O. LARSON, President-elect: Mr. Chairman, gentlemen of the Council: I have one item upon which to report. You will recall that at the September 17 meeting of the Council, the chairman of the Council appointed a special committee to investigate and see what the facilities were in Fort Wayne prior to holding our next

annual convention there. A committee was appointed to do this.

The following Thursday Jim Waggener and Mrs. Larson and I met in Fort Wayne together with a man by the name of Dupras, who certainly knows his business when it comes to exhibits and the problems of exhibitors at large conventions. A large group of the Fort Wayne doctors and the Chamber of Commerce were represented, Larry Pickering was there, the Executive Secretary of the Allen County Medical Society.

We were entertained at luncheon and a presentation was made by the people from the Chamber of Commerce, to Larry Pickering. Gene Senseny was there, Bill was there, Maurice Glock was there, the president of the Woman's Auxiliary was there. Following an outline of the facilities, including hotel facilities, meeting places for convention proper, we made a tour of the Chamber of Commerce building, which is right next to the Shrine Temple and most of the meetings would be held in those two buildings.

I'd like to state that never in my life have I seen a building so beautifully cared for and as clean a building as the Shrine Temple, particularly the basement, which would house the scientific exhibits and the various exhibits. Mr. Dupras measured all the available space and found that it was very adequate for the number of exhibitors we would have. He also found that the electrical supply was adequate to serve the needs of the exhibitors. From there we went upstairs to the main auditorium or main theater where most of our scientific meetings would be held. It's a large theater, seats many people.

Mr. Dupras has panels which he said he could place in this theater on the side aisles and in back of the middle aisle which would in effect produce a small theater which would just about satisfy our needs beautifully. Then of course there are other rooms available and a number of other places in town. We then had a conference with the manager and owner of the Van Orman hotel. We were shown a number of rooms in the hotel, and it was recommended the Van Orman be our headquarters hotel. Many of the rooms in the Van Orman hotel have been recently redecorated, and have new furniture in them. The Presidential Suite was very beautiful.

I think in brief that gives you a pretty fair idea of what we found when we visited Fort Wayne. The only reservation which I might have about going there is this: I think there may be some of our

members a little disappointed at some of the hotel accommodations which are available there. But I think overall, the facilities for the state convention of our association would be very satisfactory in Fort Wayne and the committee will recommend that we have our next annual convention in Fort Wayne. Now if there are any questions, I think perhaps Jim might be able to answer a few technical questions that I may not have gone into and I will be very happy to answer any other questions. Jim, is there anything else you want to say about that meeting?

MR. WAGGENER: No, I think you've covered it, sir.

On motion of Dr. Petrich, taken by consent, the Council commended the special committee on convention arrangements for its excellent report.

DR. LESTER H. HOYT, assistant treasurer, reported that final figures for the fiscal year, ending September 30, were not yet available, but he could report as follows (as of September 30):

General Fund

Income to date	\$252,513.40
Total expense to date	221,739.50

Revenue over expense to date	\$ 30,773.90
Total Assets,	

General Fund	\$231,503.05
Obligations	81,617.81

Net cash and investments,	
General Fund	\$149,885.24
<i>Journal</i>	

Income to date	\$ 79,847.46
Total expense to date	75,753.05

Revenue over expense to date	\$ 4,094.41
------------------------------------	-------------

"The other funds are essentially the same as published in the treasurer's report in the September *Journal*, with the exception of the Medical Defense Fund which has an outstanding statement for legal services for \$4,698.00. Dr. Everly reports that our building is paid for, and the Pennsylvania Street property is almost paid for."

DR. FRANK B. RAMSEY, Editor of *The Journal*: I have a financial statement here for *The Journal* for the fiscal year prior to audit. We came out with revenue over expense of about \$4,100.00. This was produced by a combination of advertising which brought in \$2,500.00 more than expected and other income of \$1,100.00 above budget, together with the printing bill which was \$6,000.00 more than we expected, an engraving bill of \$1,000.00 more, plus mailing expenses which were \$1,500.00 more. The fact that we didn't come up short with such a large printing bill was due to the fact that we have economized

on salaries. Mr. Waggener has almost reduced our office force to one girl. She has one part-time assistant, but we essentially give credit to Mrs. Stahl for doing a splendid job in the office almost all by herself, where previously two persons were kept busy.

We continue to see an adequate amount of scientific editorial material and we are actually becoming more and more oriented with the scientific output at the medical school and each few months we acquire new features along this line. That part of our scientific program is working out very well.

Our advertising revenue in dollars this year is 25% over what it was last year. We increased our advertising rate by about two percent, effective the first of July, to cover increased printing costs, and I believe that that will help balance the budget next year.

Delegates to the AMA: Drs. Owsley, Shields, Bibler and Hoyt discussed Resolution No. 123, which was introduced at the Atlantic City meeting in June, and the manner in which it was passed, and this was accepted as a matter of information.

DR. LESTER D. BIBLER, AMA Board of Trustees member, brought the following matters to the attention of the Council:

1. Conveyed regrets of Dr. Dwight L. Wilbur, president-elect of the AMA, for not being able to attend the ISMA state convention. "In inviting the AMA president and president-elect to Indiana it would be well to give them a six-month notice, if at all possible, as their itinerary is set up far in advance. Dr. Wilbur is interested in coming to Indiana to go over the educational format which Dr. Irwin has explained so well."

2. Next meeting of Board of Trustees will be held October 24, 1967, at which time the budget will be discussed.

3. Conference on Health Care of the Poor, in Chicago, December 15-16, 1967. Information will be sent out on that later.

4. Plan for a joint liaison committee between the AMA and the American Nurses Association. A preliminary meeting on this subject will be held in Houston in November.

5. The Board of Trustees has requested the Liaison Committee on Specialty Boards to expedite the request of the Academy of General Practice for specialty board consideration. "We would like your support on this."

6. Dr. Frank Green has been appointed to the Insurance Claims Review Committee of the AMA.

7. The Inter-Specialty Committee, an organization of the various specialties, plans to work with the Joint Accreditation Commission of Hospitals relative to setting

up a different format whereby the relationship between the hospitals and the county medical societies may be improved to get better participation in attending meetings.

8. Question of Blue Cross asking for a grant from HEW to study the question of group practice and various other subjects. "As you know, a resolution from the House of Delegates indicated a difference of opinion about accepting funds for such purposes. It might be well to discuss this matter with our Blue Cross representative, as to whether it is acceptable."

9. An educational speaker's bureau program, which is available to the states. This includes a pamphlet of instructions, recording and televising of speeches with play-back, to enable speakers to see their mistakes. Necessary equipment is supplied by the AMA.

Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman of the Executive Committee, presented the following matters:

1. *Better Business Bureau membership for 1968.* On motion of Drs. Petrich and Kerr, the Council authorized the payment of \$175.00 for membership in the Better Business Bureau for 1968.

2. *Blue Shield Board of Directors.* In the interest of establishing more direct communications between the Council and Blue Shield, the Executive Committee recommended that the councilor of the Second District, Dr. Joe Dukes, be nominated to fill the vacancy on the Blue Shield Board caused by the death of Dr. C. Philip Fox of Washington. On motion of Dr. Corcoran, seconded by many, Dr. Joe Dukes is to be recommended to the Blue Shield Board for election, to fill the unexpired term of Dr. Fox, ending March, 1969.

Economic and Organization Matters

1. *Remission of state dues.*

- a. On motion of Drs. Donato and Kerr, remission of the state dues for one year (1968) of a member of the Seventh District, because of financial hardship, was approved.

- b. On motion of Drs. Clark and Donato, remission of state dues of a member of the Twelfth District for 1968, due to retirement, was approved.

2. *Election of two members to Trust Committee of Indiana Medical Education Foundation, for the three-year term ending October 31, 1970.* On motion of Drs. Petrich and McIntosh, Dr. Loren H. Martin was elected to succeed himself

as a member of the Trust Committee of the Indiana Medical Education Foundation for the three-year term ending October 31, 1970.

On motion of Dr. Donato, taken by consent, Dr. Lester D. Bibler was elected a member of the Trust Committee for the three-year-term-expiring October 31, 1970. Membership of this committee for the ensuing three years is as follows:

	<i>Term Expires</i>
Jack H. Hall, Indianapolis	Oct. 31, 1968
Robert D. Pickett, Indianapolis	Oct. 31, 1968
Donald E. Wood, Indianapolis	Oct. 31, 1969
Roy Geider, Indianapolis	Oct. 31, 1969
Lester D. Bibler, Indianapolis	Oct. 31, 1970
Loren H. Martin, Indianapolis	Oct. 31, 1970

3. *Election of two members to Editorial Board.* On motion of Drs. Petrich and McIntosh, Dr. W. D. Snively, Jr., Evansville (pediatrics and administrative medicine), and Dr. Jene R. Bennett, South Bend (pathology) were elected members of the Editorial Board for the three-year term ending December 31, 1970.

4. *Election of Editor and five Associate Editors of The Journal for 1968.* On motion of Dr. Taylor, seconded by many, Dr. Frank B. Ramsey, Indianapolis, present editor, and associate editors, Drs. A. W. Cavins, Terre Haute, Lall G. Montgomery, Muncie, David A. Bickel, South Bend, Samuel R. Mercer, Fort Wayne, and I. W. Wilkins, Indianapolis, were re-elected for 1968.

Matters from Committees and Commissions

1. *Convention Arrangements.* Dr. Richard B. Hovda, chairman, spoke briefly on the arrangements for the convention and asked for suggestions that might be useful in planning the 1968 convention.

2. *Comprehensive health plan and other federal legislation.* Mr. Robinson reported on legislation pending in the Congress.

New Business

1. *State Board of Medical Registration and Examination.* Dr. Merritt O. Alcorn, president, State Board of Medical Registration and Examination, discussed the proposed federation of State Board's medical licensure examination program which the Indiana State Board of Examination is considering. Further discussion by Drs. Taylor, Petrich, Owsley, Shields and the Council chairman included the following points:

- (a) The great increase in the past three years of foreign graduates taking the Indiana Board examinations;
- (b) Concern of Commission on Medical Education and Licensure regarding type of examinations given;
- (c) Examinations institute, to which Dr. Merchant, a member of the Ohio State Board, and members of each group represented on the State Board were invited, and the recommendation of this group that the examination of the National Board of Medical Examiners be used;
- (d) Cost of National Board exams estimated at about \$56.00 each, which would present a problem because of lack of State Board funds.

On motion of Drs. Reid and Kerr, the Council adopted the following resolution, for presentation to the House of Delegates:

Subject: FUNDS FOR STATE BOARD OF MEDICAL REGISTRATION AND EXAMINATION

BE IT RESOLVED, that the Indiana State Medical Association support and encourage the Indiana State Board of Medical Registration and Examination to use the new multiple testing procedure as developed by the Federation of State Medical Boards for testing applicants for medical license to practice in Indiana, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association urge the Indiana legislature to appropriate sufficient funds to the Medical Board to conduct the Board in a manner as prescribed by law and to allow them to conduct this new type of examination.

2. Allied health agencies. On motion duly made, seconded by Dr. Kerr, put to vote and carried, the following resolution was adopted, for presentation to the House of Delegates:

Subject: POLICY ON ALLIED HEALTH ORGANIZATIONS

BE IT RESOLVED, that the Council of the Indiana State Medical Association recommends to the House of Delegates that it adopt a policy of discouraging allied health agencies from infringing on the clinical practice of medicine and that the House refer this matter, after adoption, to the Commission on Inter-Professional Relations for implementation.

3. Resolutions to be introduced in the House of Delegates. Each councilor was supplied with copies of all resolutions to be introduced in the House of Delegates

which had been received in the headquarters office prior to the Council meeting.

By consent the Council voted to request, at the first meeting of the House, a temporary suspension of the rules in order that action might be taken on resolution No. 12 concerning reference committee reports, to change the policy adopted by the House in 1963 requiring that reference committee reports be completed 24 hours in advance of the final meeting of the House, to "12 hours in advance of the final meeting."

Adjournment

By consent, the Council recessed at 11:30 a.m., to convene again at 8:00 a.m., Tuesday, October 10, 1967, in the Walnut Room of the Columbia Club, Indianapolis.

THE COUNCIL

October 10, 1967

The Council convened again at 8:00 a.m., EST, Tuesday, October 10, 1967, in the Walnut Room, Columbia Club, Indianapolis, with Dr. Lowell H. Steen, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Patrick J. V. Corcoran, Evansville

Gilbert M. Wilhelmus, Evansville, alternate

Second District—Joe Dukes, Dugger

Third District—Donald M. Kerr, Bedford

Fourth District—Robert M. Reid,

Columbus

Jack E. Shields, Brownstown, alternate

Fifth District—Wilbert McIntosh, Riley

Sixth District—William R. Tindall, Shelbyville

Stephen D. Smith, Knightstown, councilor-elect

Frank H. Green, Rushville, alternate

Seventh District—Albert M. Donato, Indianapolis

Eighth District—Donald R. Taylor, Muncie

Paul W. Sparks, Winchester, alternate

Ninth District—Peter R. Petrich, Attica

Tenth District—Lowell H. Steen, Whiting

Herman Wing, Gary

Eleventh District—Lowell J. Hillis, Logansport

James A. Harshman, Kokomo, alternate

Twelfth District—William R. Clark, Fort Wayne, alternate, and councilor-elect

Frederic L. Schoen, Fort Wayne, alternate councilor-elect

Thirteenth District—Otis R. Bowen, Bremen

George B. Gattman, Elkhart, alternate

Officers:

Eugene S. Rifner, Van Buren, president
G. O. Larson, LaPorte, president-elect
Lester H. Hoyt, Indianapolis, assistant treasurer

Executive Committee:

Ralph V. Everly, Indianapolis, chairman
Burton E. Kintner, Elkhart, member

Guests:

Harold C. Ochsner, Indianapolis, AMA delegate

Eugene F. Senseny, Fort Wayne, AMA delegate

Guy A. Owsley, Hartford City, AMA delegate

Robert M. Brown, Marion, AMA alternate delegate

Kenneth O. Neumann, Lafayette, AMA alternate delegate

Lester D. Bibler, Indianapolis, AMA trustee

Theodore L. Light, Dayton, Ohio, president-elect, Ohio State Medical Association

W. J. Brown, Chicago, AMA field representative

Staff:

Robert Robinson, attorney

James A. Waggener, executive secretary

The Council proceeded with the discussion of items which were listed on the agenda for the October 9, 1967, meeting, consideration of which time did not permit.

Matters from Council Liaison Committees

1. Council Liaison Committee with Blue Shield. The definition of "usual" and "customary" was discussed by many. **On motion of Drs. Rifner and Petrich, the Council voted to uphold the last definition adopted by the Council on April 16, 1966, which follows:**

"It is the official policy of this association that every physician bill and receive for his professional medical services, his usual, customary and reasonable fee. 'Usual and customary and reasonable fee' is defined as follows:

USUAL: The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patients, (i.e., his own usual fee)."

No change.

"CUSTOMARY: A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service

within the same specific and limited geographical area."

REASONABLE: A fee is 'reasonable' when it meets the usual and customary criteria or, in the opinion of a duly constituted medical society review committee, is justified under what is considered a complexity of treatment which merits special consideration.

At the July 30, 1967, Council meeting, the Council adopted the following clarification of this definition:

The term "usual and customary fee" shall mean and shall be defined and used as the "usual and customary fee" of the physician. The term "prevailing fee" shall mean and shall be defined and used as the prevailing fee of the physician.

The term "reasonable fee" shall mean and shall be defined and used as the reasonable fee of the physician. The use of any other term similar to or in place of "usual and customary fee," "prevailing fee," or "reasonable fee" shall mean and shall be defined as the fee of the physician.

2. *Council Liaison Committee with Blue Cross.* Dr. Taylor, chairman, reported on the following matters:

(a) Blue Cross plans to build a new office building at the corner of Illinois and Market streets; (b) At the last Blue Cross Board of Directors meeting, one of the hospitals in Evansville asked for a policy statement on how Blue Cross would react to the hospital building a professional office building on the hospital property . . . how would Blue Cross react to fee schedules, and so forth that might be tied in with this new office building. Dr. Taylor said, "This may represent a new departure in this area."

(c) Letter received from Mr. Spring reporting that the Council on Financing and Prepayment of the Indiana Hospital Association, in meeting on September 7 and 8, made the following recommendation to the Board of Directors of IHA: "To hold separate meetings of pathologists, and radiologists, of the state medical association, for the purpose of discussing future possible separation of professional fees from the hospital charges." Dr. Taylor: "In other words, at least a group

within the Indiana Hospital Association is finally recognizing, and is at least willing to discuss this matter, and is recommending to its Board of Directors that some meetings be set up concerning this. . . . There is some indication we are getting a breakthrough."

Discussed by Drs. Corcoran, Wilhelmus, Hoyt, Neumann and Bibler.

3. *Council Liaison Committee on Emergency Medical Services.* Dr. Hillis, chairman, announced that a meeting on Emergency Medical Care is to be held in Colorado and the question of whether or not the chairman of the Emergency Medical Services Committee should be sent to that meeting was referred to the Executive Committee.

4. *Orientation of New Members.* Dr. Corcoran, chairman of the Council Committee on Economics and Fiscal Matters, reported that his committee had been presented with a request for a \$3,000.00 appropriation to finance an orientation program for new members, provided the Council decides to set up such a program. At the initial orientation committee meeting on September 30, 1966, the president assigned this matter to the Commission on Special Activities and the commission submitted a program to the Council with the request for the \$3,000.00 to implement it. The Council withheld any action pending possible modification to be considered at this year's meeting of the House of Delegates. The Council therefore will have to wait the action of the House of Delegates.

General Discussion

The chairman enumerated some matters to which the medical profession should give some leadership: (1) subject of Emergency Medical Services; (2) traffic safety; (3) standardization of ambulances; (4) areawide planning, and (5) medical education.

Dr. Donato spoke of the poor communications system within the association, as revealed in a reference committee which he had attended on October 9. It was brought out that the members do not read *The Journal* or they would have known that the Council had resolved many of the problems they were discussing. It was the consensus of the members of the Council

that they are failing to get to the grass roots because of apathy, lethargy and disinterest.

Dr. Reid said, "Relative to communications, I have a prize district in that it is totally disjointed. There is no functional pattern, the units are strictly individual, functional units with virtually no common interest and there is no logic for a district of that kind as a medical embassy. I think it might be proper at some time to give some thought to changing the districts in this regard because I think the functional considerations within the district and with regard to areawide planning are very important now. It seems to me that you can't force communications interest, it has to be a natural sort of thing—you have to adapt your communications lines to existing functional interest lines."

Dr. Robert Brown suggested that important administrative matters be printed on colored paper in *The Journal*, in order to call member's attention to such matters.

Dr. Hillis suggested that a summary of the actions of the Council be published in *The Journal*.

Dr. Bibler commented that both the AMA and the American Academy of General Practice had passed resolutions recommending that there be more active participation and representation of physicians on the boards of trustees of hospitals.

There being no further business, the meeting was adjourned.

THE COUNCIL

October 12, 1967

The Council met for organizational purposes at the conclusion of the House of Delegates meeting on Thursday, October 12, 1967, in the Ballroom of the Columbia Club, Indianapolis, with a quorum present.

By unanimous ballot Dr. Lowell H. Steen, Hammond, was elected chairman of the Council.

On motion duly made and seconded, Dr. Ralph V. Everly and Dr. Burton E. Kintner were re-elected members of the Executive Committee.

There being no further business the Council adjourned to meet again at 10:00 a.m., on Sunday, November 19, 1967. ◀

COMMERCIAL ANNOUNCEMENTS

NEEDED: General practitioner and internist for cosmopolitan small Indiana resort town. Home of Culver Military Academy. Located on beautiful Lake Maxinkuckee. Salary \$18,000 up depending on experience leading to early association or partnership. Contact Joseph D. Howard, M.D., Culver, Ind. Phone 842-3568.

FOR SALE: Medical practice in northern Indiana lake region. Association with two other G.P.'s in modern, fully furnished and equipped office, with lab, x-ray and pharmacy. Write Box 347, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

FOR SALE: Large medical practice in a town of 50,000; hospital; grossing \$85,000 to \$90,000 a year. Will introduce and provide office. Available any time. Reasonable terms can be arranged. Write Box 344, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

PSYCHIATRIC RESIDENCIES: Accepting applications for January and July, 1968. Balanced didactic-clinical program providing extensive, varied experience with both inpatient and outpatient adults and children. Fully approved 3 year training. Three year plan: \$8,978; \$9,417; \$10,210. Five year career plan: \$10,231; \$11,797; \$13,739; \$17,497; \$18,458. Located in Michigan's serene, scenic water wonderland. Contact Dr. Paul E. Kauffman, Director of Training, Traverse City State Hospital, Traverse City, Michigan, 49684. An equal opportunity employer.

LOCUM TENENS WANTED: May and June, 1968, for general practice, including OB and minor surgery. Three fine hospitals; all specialties available for consultation. \$1,000 a month. Write R. B. Juergens, M.D., 1724 Prairie Lane, Fort Wayne, Ind., or call 219-748-0608.

WANTED: Physician or physicians to operate emergency room at St. Francis Hospital. Four doctors needed for full-time coverage. Guaranteed minimum annual stipend. Contact committee members: Dr. A. L. Blake, Dr. Charles Dill or Dr. Robert Nagan, St. Francis Hospital, Beech Grove, Ind.

WANTED: G.P. interested in joining already established physician in large and increasing practice. New office with separate wing for associate. Two local hospitals for services. Pleasant working conditions and community. Contact Dr. John R. VanKirk, 2496 Sycamore Lane, West Lafayette, Ind. 47906.

MODERN OFFICE SPACE AVAILABLE AT PRIME EASTSIDE LOCATIONS

• Community Medical Building
• Eleventh & Arlington Avenue
Newly decorated professional offices. Pharmacy at both locations. For information contact
JUSTUS COMPANY
357-8055 Mr. Ernst

HUNTERS: Roy Martin & Sons Hunting Preserve, Route 7, Box 243, Muncie, Ind., is now open for business. We have plenty of good flying quail, chukars and pheasants. Rates on release: quail, \$2.00; chukars, \$3.00; pheasants, \$3.50. Dogs and guides available. For further information, call 317-284-8939, Muncie, Ind.

PARTNER WANTED: General practice; M.D. in early 30's in central Indiana town of 12,000 (less than 30 miles from Indianapolis) desires to share a good income, active family practice. A progressive town with a well-equipped, 100-bed hospital and a good medical atmosphere. New ultra modern office. Write Box 343, The Journal, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

BUY AND TRY: Wye Plantation Aberdeen-Angus frozen semen from Advanced Register P.R.I. sires officially gaining over four pounds per day or whose 365-day weights are above 1,200 pounds. (Performance tested sires always for sale.) **WYE PLANTATION, Queenstown, Maryland 21658. Telephones: 301-827-7166 or 301-827-7160.**

FOR SALE: By distributor—Electronic telephone answering and recording equipment. Eliminates answering services. No installation. Fully transistorized. Utilizes voice induction—high fidelity. Performs dictaphone services. Tax deductible. Comparatively low cost. American made. Guaranteed. Specifications and prices furnished without obligation. No salesman. Wellington House, City Hall, 107 Ventura, Ojai, Calif. 93023.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.)

will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: \$3.00
each additional line: 50¢

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

ADVERTISERS IN THIS ISSUE

December 1967

Volume 60

No. 12

Ames Company, Inc.	1708-09	Medical Protective Co. of Ft. Wayne	1677
Armour Pharmaceutical Company	1617	Mutual Medical Insurance, Inc.	1627
Burroughs Wellcome & Co., Inc.	1638	Parke, Davis & Company	2nd Cover
Campbell Soup Company	1699	Pitman-Moore Company	1634-35
Carnation Company, The	1722-23	Poythress, Wm. P. & Co., Inc.	1674, 1706, 1712-13
Coca-Cola Company	1720	Quality Leasing	1629
Dorsey Laboratories	1669	Robins, A. H. Company, Inc.	1690-21, 1637
Geigy Pharmaceuticals	1624-25, 1678-79	Roche Laboratories	4th Cover
Hanger, J. E., Inc.	1707	Sandoz Pharmaceuticals	1672-74
Harding Hospital	1752	Searle, G. D. & Co.	1700-01
Heid's Shoe Store	1710	Smith Kline & French Laboratories	1615
Hynson, Westcott & Dunning, Inc.	1611	Stuart Company, The	1613
Indiana Bell Telephone Company	1645	Syntex Laboratories, Inc.	1639-44
Indiana Medical Bureau	1683	Wabash Valley Hospital	1663
Lederle Laboratories	1661-62, 1671	Winthrop Laboratories	1685
Lilly, Eli & Company	1646, 1702-04, 1718-19		

In accepting advertising for publication, *The Journal* has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services, and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated, or implied by the association.

The JOURNAL

of the

INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

•

EDITOR

FRANK B. RAMSEY, M.D., Indianapolis

ASSOCIATE EDITORS

A. W. CAVINS, M.D., Terre Haute
DAVID A. BICKEL, M.D., South Bend
SAMUEL R. MERCER, M.D., Fort Wayne
LALL G. MONTGOMERY, M.D., Muncie
IRVIN W. WILKENS, M.D., Indianapolis

EDITORIAL BOARD

HAROLD D. LYNCH, M.D., Evansville
ALVIN J. HALEY, M.D., Fort Wayne
JENE R. BENNETT, M.D., South Bend
WEI-PING LOH, M.D., Gary
JACK W. HICKMAN, M.D., Indianapolis
FRANK H. COBLE, M.D., Richmond

ASSISTANT EDITOR

MRS. JACKIE FREERS STAHL, Indianapolis

BUSINESS MANAGER

JAMES A. WAGGENER, Indianapolis

•

Office of Publication: 3935 North Meridian Street, Indianapolis, Indiana 46208

INDEX TO VOLUME 60

January through December, 1967

January	Pages	1 to 116	July	Pages	883 to 998
February	Pages	117 to 244	August	Pages	999 to 1132
March	Pages	245 to 382	September	Pages	1133 to 1314
April	Pages	383 to 508	October	Pages	1315 to 1474
May	Pages	509 to 634	November	Pages	1475 to 1610
June	Pages	635 to 882	December	Pages	1611 to 1792
December 1967					1785

SCIENTIFIC ARTICLES

Alcoholism, An Addition to the Somatic Treatment of, (Matthew)	1650	Dental Anesthesia, Medical Factors in Outpatient, (Herd-Waldo)	1345
Aldosteronism, Primary: Case Report with Plasma Renin Suppression (Maroon-Lukemeyer)	27	Diabetes Mellitus, Juvenile, Cystic Fibrosis and, A Case Report, (Poncher-Rowley-Traisman)	907
Amniotic Fluid, Spectrophotometric Examination of, as a Means of Predicting Severity of Intrauterine Erythroblastosis (Muller)	914	Digitalis, Treatment of Arrhythmias due to, (Fisch)	146
An Addition to the Somatic Treatment of Alcoholism (Matthew)	1650	Dr. John S. Bobbs of Indiana, the First Cholecystotomist (Sparkman)	541
Anesthesia, Dental, Medical Factors in Outpatient, (Herd-Waldo)	1345	Duodenum, Pseudotumor of the Stomach and, (Moss-Shuck)	275
Aneurysm of the Hepatic Artery: Report of a Case, (Schermer)	1652	Electrocardiography, High Fidelity, (Anderson)	1516
Arrhythmias, Treatment of, due to Digitalis, (Fisch)	146	Electrophysiology Laboratories (Greenspan-Edmands)	1537
Arrhythmias, Treatment of, Following Myocardial Infarction (Dennison-Storer)	1039	Erythroblastosis, Intrauterine, Spectrophotometric Examination of Amniotic Fluid as a Means of Predicting Severity of, (Muller)	914
Asthma: Immunological and Non-Immunological, (Caplin-Haynes)	57, 302	Exercise Laboratory (Jordan)	1552
Biosynthetic Systems, The Control of, (Gibson)	918	Femoral Neck, Stress Fractures of the, (Rapp-Moody)	424
Blood Flow, Coronary, (Knoebel-McHenry)	1526	"Functional" T Wave Changes (King-Schuster)	183
Bobbs, Dr. John S., of Indiana, the First Cholecystotomist (Sparkman)	541	Gallbladder, Mary Wiggins Burnsworth of Indiana, the First Person to Undergo Operation upon the, (Sparkman)	549
Burnsworth, Mary Wiggins, of Indiana, the First Person to Undergo Operation upon the Gallbladder (Sparkman) ..	549	Hepatic Artery, Aneurysm of the, Report of a Case, (Schermer)	1652
Cancer, Towards a Rational Chemotherapy of, (Weber)	417	Heredity, Cellular Development and, (Report on the American Cancer Society-sponsored work at the laboratory of Dr. Tracy M. Sonneborn, Bloomington)	1036
Cardiac Pacemakers (Storer-Dennison)	1647	High Fidelity Electrocardiography (Anderson)	1516
Cardiac Pacemakers, The Effect of Potassium on the Ventricular Excitability Threshold in Patients with Implanted, (Knoebel-McHenry)	156	Indiana University Medical Center, Comprehensive Health Planning and the, (Penrod)	1180
Cardiovascular Uses of Diagnostic Ultrasound (Feigenbaum)	1522	Infectious Mononucleosis: Current Concepts and Data from 104 Previously Unpublished Cases (Roller)	32
Catheterization, Role of Cardiac, in Clinical Cardiology, Based on 704 Consecutive Studies (Feigenbaum-Nasser) ..	160	Intensive Coronary Care Units (Storer)	1043
Cauterization, Cervicitis and Benefits from, (Peyton)	910	Krannert Institute of Cardiology, The, (Fisch)	1515
Cellular Development and Heredity, (Report on the American Cancer Society-sponsored work at the laboratory of Dr. Tracy M. Sonneborn, Bloomington)	1036	Laboratory Tests, Routine Admission, in Small Hospitals, (Christie)	1173
Cerebrovascular Accidents, The Electrocardiographic Changes in, (Anderson)	180	Malformations in Plants Caused by a Mold Product, Malformin (Report on the American Cancer Society-sponsored work at the laboratory of Professor R. W. Curtis, Lafayette)	1554
Cervicitis and Benefits from Cauterization (Peyton)	910	Malformin, Malformations in Plants Caused by a Mold Product, (Report on the American Cancer Society-sponsored work at the laboratory of Professor R. W. Curtis, Lafayette)	1554
Cholecystotomist, the First, Dr. John S. Bobbs of Indiana, (Sparkman)	541	Mary Wiggins Burnsworth of Indiana, the First Person to Undergo Operation upon the Gallbladder (Sparkman) ..	549
Cinearteriography, Selective Coronary, (Elliott)	1519	Mediastinoscopy—A Safe, Practical Technic (Siderys-Pittman)	1359
Clinical Usefulness of the Diuretic Triamterene (Collins) ..	1027	Medical Factors in Outpatient Dental Anesthesia (Herd-Waldo)	1345
Comprehensive Health Planning and the Indiana University Medical Center (Penrod)	1180	Mononucleosis, Infectious: Current Concepts and Data from 104 Previously Unpublished Cases (Roller)	32
Congenital Rubella Syndrome: Experience with 13 Cases (Effmann-Kurlander)	1350	Morquio's Disease (Hickman)	282
Coronary Blood Flow (Knoebel-McHenry)	1526	Myocardial Performance, The Determinants of, (Edmands-Greenspan)	165
Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report (Poncher-Rowley-Traisman)	907		

Necrolysis, Toxic Epidermal, Occurring in Siblings, (Hannemann)	38	The Krannert Institute of Cardiology (Fisch)	1515
Pacemakers, Cardiac, (Storer-Dennison)	1647	Towards a Rational Chemotherapy of Cancer (Weber)	417
Paramyosin Reveal Basic Cellular Physiology (Mueller) ...	1348	Toxic Epidermal Necrolysis Occurring in Siblings (Hannemann)	38
Peritonsillar Cellulitis: Report of a Case (Newsome)	42	Treatment of Arrhythmias due to Digitalis (Fisch)	146
Potassium, The Effect of, on the Ventricular Excitability Threshold in Patients with Implanted Cardiac Pacemakers (Knoebel-McHenry)	156	Treatment of Arrhythmias Following Myocardial Infarction (Dennison-Storer)	1039
Pregnancy Complicated by Pseudohemophilia (Von-Willebrand's Disease), (McCammon)	1363	Triamterene, Clinical Usefulness of the Diuretic, (Collins) ..	1027
Primary Aldosteronism: Case Report with Plasma Renin Suppression (Maroon-Lukemeyer)	27	Tuberculosis Treatment and Follow-up (Miller)	1045
Pseudohemophilia (Von-Willebrand's Disease), Pregnancy Complicated by, (McCammon)	1363	T Wave Changes, "Functional," (King-Schuster)	183
Pseudotumor of the Stomach and Duodenum (Moss-Shuck) ..	275	Ultrasound, Cardiovascular Uses of Diagnostic, (Feigenbaum)	1522
Role of Cardiac Catheterization in Clinical Cardiology, Based on 704 Consecutive Studies (Feigenbaum-Nasser)	160	Vasa Praevia (Geisler-Cline)	428
Routine Admission Laboratory Tests in Small Hospitals (Christie)	1173	Venomous Snakes of Indiana: Treatment of Their Bites (Russell)	665
Rubella Syndrome, Congenital, Experience with 13 Cases, (Eiffmann-Kurlander)	1350	(Von-Willebrand's Disease), Pregnancy Complicated by Pseudohemophilia, (McCammon)	1363
Selective Coronary Cinearteriography (Elliott)	1519		
Spectrophotometric Examination of Amniotic Fluid as a Means of Predicting Severity of Intrauterine Erythroblastosis (Muller)	914	ELECTROCARDIOGRAM OF THE MONTH	
Stomach, Pseudotumor of the, and Duodenum, (Moss-Shuck)	275	A-V Nodal (Junctional) Tachycardia in Emphysema (Fisch)	1655
Stress Fractures of the Femoral Neck (Rapp-Moody)	424	Double Tachycardia in Emphysema (Fisch)	1371
The Cancer Program at Indiana University School of Medicine—1966-1967 (Weber)	556	Nonparoxysmal A-V Nodal Tachycardia (Fisch)	296
The Cancer You View		Nonspecificity of T Wave Changes: Friedreich's Ataxia (Fisch)	432
Part 1 (Pontius)	437	Pulmonary Emphysema (Fisch)	576
Part 2 (Pontius)	582	Pulmonary Emphysema vs. Myocardial Infarction (Fisch) ..	927
Part 3 (Pontius)	930	Pulmonary Emphysema vs. Myocardial Infarction (Fisch) ..	1054
Part 4 (Pontius)	1053	Right Ventricular Hypertrophy (RVH) in Pulmonary Emphysema (Fisch)	1184
Part 5 (Evans-Bates)	1374	Ventricular Parasystole and A-V Nodal Rhythm (Fisch) ...	46
Part 6 (Dolan)	1663		
The Case of Iatrogenic Idiopathy (Lieberman)	1049	FRACTURES AND ORTHOPEDIC PROBLEMS	
The Case of the Mystifying Myelopathy (Lieberman)	920	Calcification of Cervical Intervertebral Discs in Children (Rapp-De Rosa)	574
The Case of the Wayward Bullet (Gilliland)	280	Dislocation of the Hip with Femoral Shaft Fracture (Gibson) ..	1558
The Case of Unobtainable Oblivion (Lieberman)	287	Flat Feet, Plantar Warts and Corns (Crawford)	1376
The Control of Biosynthetic Systems (Gibson)	918	Fracture of the Distal Radius with Ulnar Nerve Injury (Stark)	1058
		Posterior Dislocations of the Shoulder (Rapp)	923
		The Recognition and Treatment of Dupuytren's Contracture (Wray)	1658
		PATH-FINDER	
		Differential Diagnosis of the Month: Hemolytic Anemia (Blum)	450
		Indications for Blood Transfusion	583
		Serum Enzymes and Myocardial Infarction (Loh)	1381
		The Concurrent Determination of Urinary 17-Ketogenic Steroids and Total Neutral 17-Ketosteroids (Russell-Raymer-Lobstein)	304
		The Routine Throat Culture	1067

X-RAY CONFERENCE

Arteriographic Assessment of Internal Mammary Lymph Node Metastases (Lang)	1556
Arteriographic Demonstration of Parathyroid Adenoma (Lang)	1656
Double Contrast Barium Cystography (Lang)	298
Massive Pulmonary Infarction (Lang)	1059
Morgagni Hernia (Lang)	48
Scalenus Anticus and Pectoralis Minor Syndrome (Lang) ..	440
Superimposition Cystography (Lang)	1372
The Arteriographic Diagnosis of Periarthritis Nodosa (Lang) ..	928
Traumatic Rupture of the Aorta (Lang)	570
Vesicorectal Fistula (Lang-Allen)	1185

EDITORIALS

21st Clinical Convention of the AMA (Guest)	1388
Advertising Income of Nonprofit Organizations	1070
AMPAC, Good Year for, I-HOPE,	586
A Smelly Editorial (Guest)	588
Attacking the Old Grouch (Hickman)	670
Billsbord (Guest)	1194
Clinical Investigation: Why Make It More Difficult?	1384
Dr. E. S. Rifner, ISMA Ex-President (Guest)	1666
Drug Quality: Mind Your P's & Q's & R's (Guest)	456
Drugs—Judgment or Regulation?	1560
Fewer New Drugs Introduced	670
Generic Equivalents (Guest)	1384
Good Year for AMPAC, I-HOPE	586
Hippocrates Dropped In (Hickman)	185
Hospital Supply Sales, up, Up, UP	931
I-HOPE, Good Year for AMPAC,	586
Indiana O and O	1193
Indiana Receives Regional Planning Grant	306
Intrauterine Transfusion (Bickel)	931
Mathematics Teachers and Others (Hickman)	1666
Measles Eradication	1664
Medicare—Diagnosis and Treatment (Guest)	933
Memo From the Editor (Guest)	308
More Hospital Beds	58
Notes From a Medical Convention (Hickman)	454
"Not the Name by which it is Sold. . . ."	1664
Nursing Homes and Title VI	185
Patient Selection for Coronary Care (Dennison)	1070
PHS Warns About Motorcycles	58
PMA President Replies to Critics	1070
"Project Head Start" (Montgomery)	308
Publisher's Memo (Guest)	1561
Socialism in Saskatchewan: A Fiasco (Guest)	455
The All-Important Art of Handling Patients (Alvarez)	587
The AMA Convention—and Why We Go (Guest)	308
The Doctor is Losing His Voice (Harvey)	1069
The G. P. Club	454

The Journal Welcomes Two New Features	306
The Killer (Guest)	1561
The Myth of One-Unit Transfusions (Guest)	1193
The Old Grouch Fights Back (Hickman)	932
The Old Grouch Proposes (Hickman)	586
The Price of People: Crucial Quantity in Hospital Costs (Guest)	1386
The Social Security Disability Program in Indiana	1070
The World Medical Association, Inc.	934
Thoughts on an Old Problem (Guest)	1665
Young Driver's Record Worse (Guest)	1562

SPECIAL FEATURES

A Glimpse Inside Russia (Norman)	72
AMA House of Delegates, Report on Actions of, (20th Clinical Convention, Nov. 27-30, 1966, Las Vegas, Nev.)	201
American Cancer Society Forms Speakers Bureau	1687
A Report on the Battered Child: Indiana, 1966	469
Curling, For Winter Fun and Fitness, (Davis)	1680
Day by Day with the FDA	1577
Doctor! Take the Time! Make the Effort! (Bowen)	1264
Drug Stocks Ease	1684
Federally Approved Home Health Services Agencies In Indiana	677
For Winter Fun and Fitness: Curling (Davis)	1680
Future in Medical Care Gets Emphasis in ISMA Meeting ..	464
G. O. Larson, M.D., President, 1967-68	1564
Historical Notes (Smallwood)	1563
Indiana School for the Blind (Brashear)	1574
ISMA Annual Reception for Indiana Delegation in Congress ..	596
January Meeting of the Council	328
Marion County Association for Retarded Children Announces Expansion of Services	463
Measles Eradication, Status of, in Indiana (Marshall)	1691
Medical Students Urged to Stay in Indiana	950
Medicare Approved Independent Clinical Laboratories	678
Meet The Journal Staff	
Pt. 1	944
Pt. 2	1073
Pt. 3	1390
Pt. 4	1572
Pt. 5	1668
"North to Alaska"	949
On the Profession of Medicine (Geelhoed)	194
Open Letter to all Indiana Physicians: Testing of School Children for Tuberculosis	1096
Report on Actions of the AMA House of Delegates (116th Annual Convention, June 18-22, 1967, Atlantic City)	1089
Retail Prescription Drug Prices DOWN	390
Report on Actions of the AMA House of Delegates, (20th Clinical Convention, Nov. 27-30, 1966, Las Vegas, Nev.) ..	201
Status of Measles Eradication in Indiana (Marshall)	1691
The Passing of the Doctor (Bond)	1401
The Rocky Road Ahead (Sheeley)	459
The Doctor is Losing His Voice (Harvey)	1078

REGULAR FEATURES

About Our Cover	17, 143, 262, 410, 541, 802, 905, 1033, 1195, 1354, 1515, 1680
Abstracts, Book Reviews	92, 219, 342, 490, 614, 962, 1113, 1290, 1439, 1585, 1706
Annual Meeting Dates of Professional Medical and Allied Organizations	69, 209, 263, 497, 609, 803, 979, 1121, 1303, 1435, 1599, 1717
Blue Cross-Blue Shield Series:	
Who Said This?	63
Blue Shield's Role in Medicare	196
How Blue Shield Prepayment Started	340
Blue Shield—Roots in the Community	477
Blue Shield Operational Data: 1946-1966	601
Your Blue Shield Board of Directors	676
Blue Cross-Blue Shield News	960
Changes in Blue Shield Payment Patterns	1098
Blue Shield and Blue Cross Again Return Most in Benefits	1408
What's Ahead for Blue Shield?	1578
Physicians' Role in National Blue Shield	1698
Board of Health Report	90, 212, 266, 500, 612, 806, 982, 1124, 1306, 1438, 1602, 1720
County, District News	103, 239, 354, 503, 630, 983, 1126, 1457, 1604, 1724
Editorial Notes	186, 309, 456, 588, 934, 1071, 1194, 1388, 1563, 1667
Fourth Estate	20, 136, 267, 414, 538, 650, 902, 1021, 1160, 1340, 1496, 1630
From The Journal 50 Years Ago	30, 164, 278, 430, 532, 814, 898, 1038, 1296, 1444, 1603, 1645
Future Meetings, Seminars, Courses	101, 238, 352, 501, 629, 978, 1125, 1308, 1455, 1596, 1721
Gleaned from the British Medical Journal (Hickman)	64, 191, 473, 952, 1676
Letters to the Editor	388, 555, 1025, 1170, 1504
Medical Panorama:	
More Light on Monilial Vaginitis (Cavins)	976
Hoosier Population Trends (Cavins)	1095
Medicine At Law	80, 216, 332, 480, 604, 956, 1107, 1275, 1420, 1581, 1694
Month in Washington	14, 132, 260, 404, 528, 896, 1009, 1145, 1326, 1492, 1622
News from Indiana University School of Medicine	322, 472, 1083, 1270, 1415, 1576, 1686
News Notes	96, 228, 348, 494, 627, 971, 1118, 1298, 1451, 1591, 1711
President's Page (Rifner)	59, 189, 310, 457, 592, 672, 946, 1074, 1196, 1391
President's Page (Larson)	1566, 1670
Wanted: Locations, Physicians	89, 213, 326, 477, 601, 976, 1100, 1282, 1427, 1715
What's New?	1016, 1159, 1339, 1501, 1629
The Woman's Auxiliary Reports to ISMA	
(Scales)	62, 190, 319, 458
(Deever)	594, 674, 948, 1077, 1198, 1392, 1571, 1675

CONVENTION ISSUE

Announcement	1201
Convention Arrangements Committees	1222
Fifty-Year Club	1207
House of Delegates	1204
House of Delegates, Official Call to the,	1203
Officers of ISMA, 1966-1967	1207
Program, 118th Annual Convention	1215
Reference Committees	1222
Reports of Commissions	1240
Reports of Committees	1235
Reports of Officers	1223
Resolutions	1250
Scientific Exhibits	1251
Section Officers	1211
Technical Exhibitors	1255
Woman's Auxiliary Program	1222
Officers of the ISMA (pictures)	1208
Educational Films	1250

1967 CONVENTION

1967—The Convention Story	1725
President's Address, Eugene S. Rifner, M.D., Van Buren ...	1746
Address to the House of Delegates, G. O. Larson, M.D., LaPorte	1749
The Student American Medical Association (Green)	1753
Convention Election Results: Dr. Patrick J. V. Corcoran is Named President-Elect	1755
The Winners	1756
Index to House of Delegates Proceedings	1757

ASSOCIATION BUSINESS

Budget Committee:	
Jan. 21, 1967	363
The Council:	
Jan. 22, 1967	364
April 9, 1967	987
June 11, 1967	1128
July 30, 1967	1459
Sept. 17, 1967	1607
Oct. 9, 1967	1777
Oct. 10, 1967	1781
Oct. 12, 1967	1782
Executive Committee:	
Nov. 19, 1966	105
Jan. 21, 1967	362
Feb. 25, 1967	505
Mar. 18, 1967	631
April 8, 1967	986
June 10, 1967	1127
July 29, 1967	1310
Aug. 12, 1967	1458
Sept. 16, 1967	1606
Oct. 8, 1967	1776
Oct. 12, 1967	1776

YEARBOOK SECTION

Approved Hospitals in Indiana	807
Approved Mental Hospitals	812
Class A Narcotic Drugs	855
Community Centers for the Mentally Retarded	819
Constitution and Bylaws of the ISMA	864
Deaths of Indiana Physicians in 1966	860
Disease Prevention by Immunization and Chemoprophylaxis	844
Indiana Accredited Practical Nursing Schools	794
Indiana Accredited Schools of Professional Nursing	792
I.U. School of Medicine, Heads of Departments	801
Licensed Nursing Homes in Indiana	824
Membership Roster	
Alphabetically	1/681
By Counties	33/713
Woman's Auxiliary	71/751
Outpatient Mental Health Facilities in the State of Indiana:	
1967	836
Poison Control Centers in Indiana and Adjacent States	840
Presidents of ISMA Since Its Organization	862
Principles of Medical Ethics of the American Medical Association	879
Professional Medical and Allied Organizations	796
State Elected Officials	780
State Health Organizations	782
Voluntary Organizations	800

AUTHORS

Allen, Lawrence, M.D., (Vesicorectal Fistula)	1185
Alvarez, Walter C., M.D., (The All-Important Art of Handling Patients)	587
Anderson, Gary J., M.D., (High Fidelity Electrocardiography)	1516
Anderson, Gary, M.D., (The Electrocardiographic Changes in Cerebrovascular Accidents)	180
Bates, Laurence H., M.D., (The Cancer You View)	1374
Bickel, David A., M.D., (Intrauterine Transfusion)	931
Blum, Leon L., M.D., (Hemolytic Anemia)	450
Bond, George S., M.D., (The Passing of the Doctor)	1401
Bowen, Otis R., M.D., (Doctor! Take the Time! Make the Effort!)	1264
Brashear, Diane B., M.S.W., (Indiana School for the Blind)	1574
Caplin, Irvin, M.D., (Asthma: Immunological and Non-Immunological)	
(Part 11)	57
(Part 12)	302
Cavins, A. W., M.D., (More Light on Monilial Vaginitis) ..	976
Christie, Robert W., M.D., (Routine Admission Tests in Small Hospitals)	1173
Cline, Donald L., M.D., (Vasa Praevia)	428
Collins, Jack T., M.D., (Clinical Usefulness of the Diuretic Triamterene)	1027
Crawford, John A., M.D., (Flat Feet, Plantar Warts and Corns)	1376

Davis, Thomas N. III, M.D., (For Winter Fun and Fitness: Curling)	1680
Dennison, A. D., Jr., M.D., (Cardiac Pacemakers)	1647
Dennison, A. D., Jr., (Patient Selection for Coronary Care)	1070
Dennison, A. D., Jr., M.D., (Treatment of Arrhythmias Following Myocardial Infarction)	1039
De Rosa, G. Paul, M.D., (Calcification of Cervical Intervertebral Discs in Children)	574
Dolan, Patrick A., M.D., (The Cancer You View)	1663
Edmands, Robert E., M.D., (Electrophysiology Laboratories)	1537
Edmands, Robert E., M.D., (The Determinants of Myocardial Performance)	165
Effmann, Eric L., A.B., (Congenital Rubella Syndrome: Experience with 13 Cases)	1350
Elliott, William C., (Selective Coronary Cinearteriography)	1519
Evans, Paul V., M.D., (The Cancer You View)	1374
Feigenbaum, Harvey, M.D., (Cardiovascular Uses of Diagnostic Ultrasound)	1522
Feigenbaum, Harvey, M.D., (Role of Cardiac Catheterization in Clinical Cardiology, Based on 704 Consecutive Studies)	160
Fisch, Charles, M.D., (A-V Nodal (Junctional) Tachycardia in Emphysema)	1655
Fisch, Charles, M.D., (Double Tachycardia in Emphysema)	1371
Fisch, Charles, M.D., (Nonparoxysmal A-V Nodal Tachycardia)	296
Fisch, Charles, M.D., (Nonspecificity of T Wave Changes: Friedrich's Ataxia)	432
Fisch, Charles, M.D., (Pulmonary Emphysema)	576
Fisch, Charles, M.D., (Pulmonary Emphysema vs. Myocardial Infarction)	927
Fisch, Charles, M.D., (Pulmonary Emphysema vs. Myocardial Infarction)	1054
Fisch, Charles, M.D., (Right Ventricular Hypertrophy (RVH) in Pulmonary Emphysema)	1184
Fisch, Charles, M.D., (The Krannert Institute of Cardiology)	1515
Fisch, Charles, M.D., (Treatment of Arrhythmias due to Digitalis)	146
Fisch, Charles, M.D., (Ventricular Parasystole and A-V Nodal Rhythm)	46
Geelhoed, Glenn W., A.B., (On the Profession of Medicine)	194
Geisler, Hans E., M.D., (Vasa Praevia)	428
Gibson, Alois E., M.D., (Dislocation of the Hip with Femoral Shaft Fracture)	1558
Gibson, David M., M.D., (The Control of Biosynthetic Systems)	918
Gilliland, John E., M.D., (The Case of the Wayward Bullet)	280
Green, Barth A., A.B., (The Student American Medical Association)	1753
Greenspan, Kalman, Ph.D., (Electrophysiology Laboratories)	1537
Greenspan, Kalman, Ph.D., (The Determinants of Myocardial Performance)	165
Hannemann, Robert E., M.D., (Toxic Epidermal Necrolysis Occurring in Siblings)	38
Harvey, Paul, (The Doctor is Losing His Voice)	1078
Haynes, John T., M.D., (Asthma: Immunological and Non-Immunological)	
(Part 11)	57
(Part 12)	302

Herd, Richard M., D.D.S., (Medical Factors in Outpatient Dental Anesthesia)	1345	Maroon, Joseph C., M.D., (Primary Aldosteronism: Case Report with Plasma Renin Suppression)	27
Hickman, Jack W., M.D., (Attacking the Old Grouch) ...	670	Marshall, A. L., Jr., M.D., (Status of Measles Eradication in Indiana)	1691
Hickman, Jack W., M.D., (Hippocrates Dropped In)	185	Matthew, J. R., M.D., (An Addition to the Somatic Treatment of Alcoholism)	1650
Hickman, Jack W., M.D., (Mathematics Teachers and Others)	1666	Miller, John D., M.D., (Tuberculosis Treatment and Follow-up)	1045
Hickman, Jack W., M.D., (Morquio's Disease)	282	Montgomery, Lall G., M.D., ("Project Head Start")	308
Hickman, Jack W., M.D., (Notes From a Medical Convention)	454	Moody, David L., M.D., (Stress Fractures of the Femoral Neck)	424
Hickman, Jack W., M.D., (The Old Grouch Fights Back) ..	932	Moss, Harlan B., M.D., (Pseudotumor of the Stomach and Duodenum)	275
Hickman, Jack W., M.D., (The Old Grouch Proposes)	586	Mueller, Jo Anne, (Paramecia Reveal Basic Cellular Physiology)	1348
Jordan, John W., M.D., (Exercise Laboratory)	1552	Muller, Paul F., M.D., (Spectrophotometric Examination of Amniotic Fluid as a Means of Predicting Severity of Intra-uterine Erythroblastosis)	914
King, Robert M., A.B., ("Functional" T Wave Changes) ..	183	Nasser, William K., M.D., (Role of Cardiac Catheterization in Clinical Cardiology, Based on 704 Consecutive Studies) ..	160
Knoebel, Suzanne B., M.D., (Coronary Blood Flow)	1526	Newsome, C. K., M.D., (Peritonsillar Cellulitis: Report of a Case)	42
Knoebel, Suzanne B., M.D., (The Effect of Potassium on the Ventricular Excitability Threshold in Patients with Implanted Cardiac Pacemakers)	156	Norman, William H., M.D., (A Glimpse Inside Russia)	72
Kurlander, Gerald L., M.D., (Congenital Rubella Syndrome: Experience with 13 Cases)	1350	Penrod, Kenneth E., (Comprehensive Health Planning and the Indiana University Health Center)	1180
Lang, Erich K., M.D., (Arteriographic Assessment of Internal Mammary Lymph Node Metastases)	1556	Peyton, Frank W., M.D., (Cervicitis and Benefits from Cauterization)	910
Lang, Erich K., M.D., (Arteriographic Demonstration of Parathyroid Adenoma)	1656	Pittman, John N., M.D., (Mediastinoscopy—A Safe, Practical Technique)	1359
Lang, Erich K., M.D., (Double Contrast Barium Cystography)	298	Poncher, John R., M.D., (Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report)	907
Lang, Erich K., M.D., (Massive Pulmonary Infarction)	1059	Pontius, Edwin E., M.D., (The Cancer You View)	
Lang, Erich K., M.D., (Morgagni Hernia)	48	Pt. 1	437
Lang, Erich K., M.D., (Scalenus Anticus and Pectoralis Minor Syndrome)	440	Pt. 2	582
Lang, Erich K., M.D., (Superimposition Cystography)	1372	Pt. 3	930
Lang, Erich K., M.D., (The Arteriographic Diagnosis of Periarthritis Nodosa)	928	Pt. 4	1053
Lang, Erich K., M.D., (Traumatic Rupture of the Aorta) ..	570	Raymer, Helen, M.T., (ASCP), (The Concurrent Determination of Urinary 17-Ketogenic Steroids and Total Neutral 17-Ketosteroids)	304
Lang, Erich K., M.D., (Vesicorectal Fistula)	1185	Rapp, George F., M.D., (Calcification of Cervical Intervertebral Discs in Children)	574
Lieberman, Arnold, M.D., (The Case of Iatrogenic Idiopathy) ..	1049	Rapp, George F., M.D., (Posterior Dislocations of the Shoulder)	923
Lieberman, Arnold, M.D., (The Case of the Mystifying Myelopathy)	920	Rapp, George F., M.D., (Stress Fractures of the Femoral Neck)	424
Lieberman, Arnold, M.D., (The Case of Unobtainable Oblivion)	287	Roller, Mac C., M.D., (Infectious Mononucleosis: Current Concepts and Data from 104 Previously Unpublished Cases)	32
Lobstein, Otto E., Ph.D., (The Concurrent Determination of Urinary 17-Ketogenic Steroids and Total Neutral 17-Ketosteroids)	304	Rowley, William F., M.D., (Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report)	907
Loh, Wei-Ping., M.D., (Serum Enzymes and Myocardial Infarction)	1381	Russell, Henry M., M.D., (Venomous Snakes of Indiana: Treatment of Their Bites)	665
Lukemeyer, George T., M.D., (Primary Aldosteronism: Case Report with Plasma Renin Suppression)	27	Russell, Henry T., M.D., (The Concurrent Determination of Urinary 17-Ketogenic Steroids and Total Neutral 17-Ketosteroids)	304
McCammon, Robert E., M.D., (Pregnancy Complicated by Pseudothrombophilia (Von-Willebrand's Disease)	1363		
McHenry, Paul L., M.D., (Coronary Blood Flow)	1526		
McHenry, Paul L., M.D., (The Effect of Potassium on the Ventricular Excitability Threshold in Patients with Implanted Cardiac Pacemakers)	156		

Schermer, Kenneth L., M.D., (Aneurysm of the Hepatic Artery)	1652
Schuster, Joseph, M.D., ("Functional" T Wave Changes) ..	183
Sheeley, William F., M.D., (The Rocky Road Ahead)	459
Shuck, William, M.D., (Pseudotumor of the Stomach and Duodenum)	275
Siderys, Harry, M.D., (Mediastinoscopy—A Safe, Practical Technic)	1359
Smallwood, R. B., M.D., (Historical Notes)	1562
Sparkman, Robert S., M.D., (Dr. John S. Bobbs of Indiana, the First Cholecystotomist)	541
Sparkman, Robert S., M.D., (Mary Wiggins Burnsworth of Indiana, the First Person to Undergo Operation upon the Gallbladder)	549
Stark, William A., M.D., (Fracture of the Distal Radius with Ulnar Nerve Injury)	1058
Storer, William R., M.D., (Cardiac Pacemakers)	1647
Storer, William R., M.D., (Intensive Coronary Care Units) ..	1043
Storer, William R., M.D., (Treatment of Arrhythmias Following Myocardial Infarction)	1039
Thomas, Charles R., M.D., (The Cancer You View)	1053
Traisman, Howard S., M.D., (Cystic Fibrosis and Juvenile Diabetes Mellitus: A Case Report)	907
Waldo, J. Thayer, M.D., D.D.S., (Medical Factors in Out-patient Dental Anesthesia)	1345
Weber, George, M.D., (The Cancer Program at Indiana University School of Medicine—1966-1967)	556
Weber, George, M.D., (Towards a Rational Chemotherapy of Cancer)	417
Wray, James B., M.D., (The Recognition and Treatment of Dupuytren's Contracture)	1658

DEATHS

Adler, Edmund, M.D., Dyer (formerly)	1309
Arisman, Ralph K., M.D., South Bend	984
Asher, Ernest O., M.D., New Augusta	242
Barry, M. Joseph, Sr., M.D., Indianapolis	984
Bowman, George W., M.D., Indianapolis	504
Brayton, John R., M.D., Indianapolis	360
Bringas, Ireneo, M.D., Gary (formerly)	984
Bussard, Clifford F., M.D., South Bend	1126
Canaday, James W., M.D., Indianapolis	242
Clarke, Elton R., M.D., Kokomo	984
Culloden, William G., M.D., Indianapolis	1309
Daves, William L., M.D., Evansville	360
Dickinson, Gordon A., M.D., Petersburg	1126
Dukes, Fred M., M.D., Dugger	360
Eberwein, John, M.D., Indianapolis	1598
Faith, Ira, M.D., Evansville	504
Flanagan, Estle P., M.D., Walton	1598
Forry, Frank F., M.D., Indianapolis	504
Fox, C. Philip, M.D., Washington	1598

Gifford, Fred, M.D., Indianapolis	1598
Gill, Thomas A., M.D., Muncie	1598
Gutstein, Richard R., M.D., Kendallville	984
Hamilton, Orville G., M.D., Bluffton	984
Hansell, Robert M., M.D., Indianapolis	104
Hays, Everett L., M.D., Indianapolis	1309
Holland, D. J., M.D., Bloomington	104
James, Nicholas A., M.D., Tell City	104
Kamm, Bernard A., M.D., South Bend	1126
Keiser, Venice D., M.D., Indianapolis	104
Kenoyer, Wilbur L., M.D., Scott AFB, Ill.	1598
Kercheval, John M., M.D., Clinton	504
Knowles, Charles Y., M.D., Indianapolis	1126
Knowles, Robert P., M.D., Indianapolis	1126
Lehman, Emery W., M.D., Bluffton	984
Luckett, Coen L., M.D., Terre Haute	1598
McMichael, Frank J., M.D., Gary	984
McNabb, George B., M.D., Carthage	984
Majsterek, Stanley J., M.D., Crown Point (formerly)	360
Manalan, Maurice M., M.D., Indianapolis	504
Marcus, Emanuel E., M.D., Hammond	360
Mathys, Alfred, M.D., Mauckport (formerly)	984
Miller, Ebbo H., M.D., Valparaiso	242
Miller, Milo K., M.D., South Bend (formerly)	242
Moore, Martha, M.D., Hanover	1598
Moravec, Arthur E., M.D., Fort Wayne	504
Morrison, William R., M.D., Kokomo	1598
Murphy, Eugene C., M.D., South Bend	985
Osterman, Louis H., M.D., Seymour	242
Overpeck, Charles F., M.D., Greensburg	1309
Pettijohn, Fred L., M.D., Indianapolis	985
Porter, John R., M.D., Lebanon	104
Price, Walter S., M.D., Indianapolis	1598
Rhorer, Herbert M., M.D., Kokomo	242
Rigley, Edward L., M.D., South Bend	104
Row, Perrie Q., M.D., Hammond	985
Shoup, Homer B., M.D., Greentown	360
Showalter, John P., M.D., Waterloo	1309
Slough, Richard R., M.D., Kendallville	985
Smith, William M., M.D., LaPorte	242
Staff, Robert A., M.D., Terre Haute	504
Strong, Daniel S., M.D., Terre Haute	242
Symon, William E., M.D., Bluffton	1309
Taylor, Lon S., M.D., Elberfeld (formerly)	1126
Warvel, John H., Sr., M.D., Indianapolis	1126
Wehrman, Jule O., M.D., Indianapolis	504
Westfall, John B., M.D., Indianapolis	504
Wilhelmus, Charles, M.D., Newburgh	504
Williams, Clifford L., M.D., Indianapolis	1598
Wilson, Guy, M.D., Bicknell	985
Wiseheart, Oscar H., M.D., North Salem	360

THE LIBRARY
UNIVERSITY OF CALIFORNIA
San Francisco Medical Center

THIS BOOK IS DUE ON THE LAST DATE STAMPED BELOW

7 DAY LOAN

7 DAY

APR 16 1970

RETURNED

APR 16 1970

7 DAY

JUN 13 1973

RETURNED

JUN 15 1973

7 DAY

MAR 21 1974

RETURNED

MAR 14 1974

25m-6,'69(J951384)4315—A33-9

4.

1

